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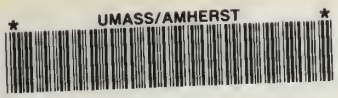

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH:

OFFICE OF STAFF TRAINING, MANPOWER PLANNING AND DEVELOPMENT

STATE HOSPITAL WORKFORCE MANAGEMENT PROJECT

STUDY NUMBER 1

Executive Summary

December, 1982

Elizabeth N. Rosenthal
Project Director

EXECUTIVE SUMMARY

INTRODUCTION

The following is a summary of a several part study of recruitment-related aspects of psychiatric hospital workforce management. The study was conducted between April and August, 1982, by staff of the Office of Staff Training, Manpower Planning and Development, a unit within the Central Office of the Massachusetts Department of Mental Health (DMH). The focus of the study was on recruitment and employment patterns of nursing staff at DMH-operated psychiatric hospitals. Supplemental data were gathered on recruitment and employment of nursing staff at publicly-operated psychiatric hospitals in other northeastern states and on licensed nurse recruitment practices in the private sector. The methodologies and findings of these distinct research components are presented in a series of reports. The series includes:

REPORT I	DMH PSYCHIATRIC HOSPITALS: RECRUITMENT
REPORT II	DMH PSYCHIATRIC HOSPITALS: EMPLOYMENT PATTERNS
REPORT III	NORTHEAST REGION PUBLIC SECTOR PSYCHIATRIC HOSPITALS: RECRUITMENT AND EMPLOYMENT
REPORT IV	PRIVATE SECTOR HOSPITALS: RECRUITMENT
REPORT V	LITERATURE REVIEW: RECRUITMENT AND RETENTION

Summary findings of analyses conducted across these research components are presented below. These findings are followed

tinue to receive recruitment training. They reported spending 60-100% of their time on the recruitment of licensed nurses.

Recruitment Methods

The data indicate that recruitment practices at DMH-operated hospitals are similar to the practices of other publicly operated psychiatric hospitals in the northeastern United States. In the public sector, use of personal contacts uniformly was identified as the most common and most effective method of recruitment. Both throughout the northeast and within Massachusetts, public sector psychiatric hospitals varied in their use of formal recruitment methods (e.g. advertising, visiting nursing schools, attending conferences, etc.).

At private sector hospitals, the data suggest that a wider range of recruitment methods is more frequently employed. Nurse recruiters surveyed in the northeastern states most often characterized local advertising as the most successful recruitment method; however, nurse recruiters interviewed at four private sector hospitals in Massachusetts emphasized the importance of ongoing recruitment activities. These activities are not directed toward the immediate filling of specific positions, but rather toward keeping the hospital name circulating in the nursing community.

Recruitment Constraints

At the DMH-operated hospitals, research findings indicate that

the poor image of the state system is the single most serious constraint to the recruitment of licensed nurses. Specifically, interviewed respondents cited the uncertain lifespan of their hospitals as a major recruitment disincentive. By contrast, recruiters interviewed at private sector hospitals in Massachusetts cited their hospital's reputation as their strongest recruitment incentive.

In both the public and the private sectors, recruiters felt constraints associated with their budgets. Only half of those interviewed at DMH-operated hospitals reported having knowledge of monies specifically budgeted for recruitment in fiscal year 1982. Those who accessed recruitment funds typically did so from what is referred to as discretionary allotments within area budgets. At private sector hospitals surveyed in the northeast region, the average nursing recruitment budget during calendar year 1982 was reported to be $90,532 or $210.54 per bed. The private sector recruiters interviewed in Massachusetts felt constrained both by the size of their budget and by the administrative restrictions on their budget allocations.

Employment Patterns

Analysis of the average ratio of actual nursing staff (licensed and unlicensed) to patients at DMH-operated hospitals and on psychiatric wards of general hospitals in Massachusetts revealed that at the DMH-operated hospitals licensed nurses comprise under 33% of the nursing staff, while at the general hospitals 60% of

these staff are licensed nurses.[1]

Findings on DMH-operated hospitals support the hypothesis of DMH executives that differences between geriatric and other inpatient units are reflected in inpatient staff employment patterns. Illustrative findings include:

- The quick turnover rate (the rate of turnover of those hired during FY'82) among licensed nurses of non-geriatric units is lower (56%) than that of geriatric units (84%).
- The quick turnover rate among unlicensed nursing staff of non-geriatric units (74%) is markedly higher than that of geriatric units (34%).
- For all nursing staff positions (RNs, LPNs, MHAs), the length of current vacancies is greater in geriatric than in non-geriatric units.

RECOMMENDATIONS

This section presents recommendations to Department of Mental Health (DMH) policy makers based on a study of recruitment-related aspects of psychiatric hospital workforce management.

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[1] Staff to patient ratios at the DMH-operated hsopitals were derived from personnel records and unit respondents' reports in FY'82. Ratios for the general hospitals were derived from data published in 1981. See the "Methodology" section of Report II.

RECOMMENDATION 1. Establish an ongoing, site-specific recruitment function, coordinated among inpatient units and among hospitals.

RECOMMENDATION 2. Develop fiscal year budgets with funds specifically earmarked to support recruitment activities.

RECOMMENDATION 3. Develop the personnel data management function to support recruitment planning.

RECOMMENDATION 4. Clarify the Department's policy regarding the current and future role of the DMH-operated hospitals within the mental health system, and design recruitment strategies that are in accord with this policy.

RECOMMENDATION 5. Establish realistic recruitment strategies and guidelines that strengthen the credibility and viability of the recruitment function, thereby promoting its efficient, effective use.

RECOMMENDATION 6. Develop the recruitment skills of employees who have recruitment responsibilities.

Because the primary focus of the research documented in the series of reports summarized in the "Introduction" of this Executive Summary was on nursing staff recruitment at hospitals operated by the Department of Mental Health, the recommendations presented above specifically address hospital nursing staff recruitment. In addition to data on recruitment, the study generated data on hospital nursing staff orientation and retention practices and personnel record keeping. Staff of the Office of Staff Training, Manpower Planning and Development (OSTMPD) who conducted this research are available to work with policy makers and administrators on operationalizing and implementing the above recommendations, and to provide supplemental analyses and reports upon request.

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH:

OFFICE OF STAFF TRAINING, MANPOWER PLANNING AND DEVELOPMENT

STATE HOSPITAL WORKFORCE MANAGEMENT PROJECT

STUDY NUMBER 1

Preface

December, 1982

Elizabeth N. Rosenthal
Project Director

D R A F T

PREFACE

BACKGROUND

The State Hospital Workforce Management Project is an ongoing effort of the Massachusetts Department of Mental Health's Office of Staff Training, Manpower Planning and Development. The intent of the Project is to assess staff recruitment, retention and utilization efforts and outcomes at DMH-operated psychiatric hospitals and the relation of these to DMH service goals.

The Project was initiated in April, 1982. At that time, two DMH-operated psychiatric hospitals had been decertified and a third was facing possible decertification, the result of failing to meet eligibility requirements for the receipt of federal funds under Title XIX.[1] In all three cases the monitoring agency had assessed as inadequate the staffing of DMH hospitals' inpatient units. Concurrently, both within the Department of Mental Health and at the level of Executive Office of Human Services, questions were being raised concerning the operational effectiveness of the hospitals' organizational structures.[2] In addition, following the former administration's policy of deinstitutionalization,[3] the current DMH Commissioner was encouraging the agency to take a renewed interest in its psychiatric hospitals. He held the

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[1] For a discussion of Title XIX, see Appendix A.

[2] An overview of these structures appears in Report I, "DMH Psychiatric Hospitals: Recruitment."

[3] See "Mental Health Crossroads: The Report of the Blue Ribbon Commission on the Future of Public Inpatient Mental Health Services in Massachusetts," Boston, 1981.

position that as well as meeting Federal certification requirements for Title XIX eligibility, the Department should meet the standards of the Joint Commission on Accreditation of Hospitals (JCAH).

It was recognized that in order to formulate policies for the DMH-operated hospitals that would be both compatible with the Department's overall service goals and realistic, DMH policy makers would require a thorough understanding of ongoing workforce management issues and practices at these institutions. The State Hospital Workforce Management Project was initiated with this need in mind.

STUDY NUMBER 1

Overview

The Project's first study addresses recruitment-related aspects of psychiatric hospital workforce management. The focus of the study was on inpatient nursing staff. At the DMH-operated hospitals this included licensed nurses and unlicensed nursing staff.

The study was designed as several distinct research components, the methodologies and findings of which are presented in a series of reports. The series includes:

REPORT I DMH PSYCHIATRIC HOSPITALS: RECRUITMENT

REPORT II DMH PSYCHIATRIC HOSPITALS: EMPLOYMENT PATTERNS

REPORT III NORTHEAST REGION PUBLIC SECTOR PSYCHIATRIC HOSPITALS: RECRUITMENT AND EMPLOYMENT

REPORT IV PRIVATE SECTOR HOSPITALS : RECRUITMENT

REPORT V LITERATURE REVIEW: RECRUITMENT AND RETENTION

The study is best viewed as a pilot effort. Within each research component the size of the sample was small (eight DMH inpatient units, twelve states, four private sector hospitals), and each investigation was essentially exploratory. When taken together these research efforts are sufficiently robust to be of use to policy makers.

Acknowledgments

This study was funded in large part through a grant to the Department of Mental Health from the Center of State Mental Health Manpower Development, a branch of the National Institute of Mental Health. (Grant number 5 T23 MH 15368-03.)

The study was made possible through the efforts of many individuals who provided information, advice and constructive criticism and, in a number of cases, engaged in ongoing collaboration on various aspects of the research. Within the DMH Office of Staff Training, Manpower Planning and Development these are Theresa Bulger, Jackie Bullock, Norris Colman, Diane Cummings,

Rose Daly, Bob Hallgren, Marcy Lidman, Don MacAuley, Chris Rendall, Lillian Ryan, and Chris Shane, and in the field Arthur Borsky and Nancy Reid. Significant contributions were made by several consultant program analysts; these are Ann-Marie Baronas, Eliza Childs, Marc Cohen, Ann-Charlotte Endahl, Emily Hoeffel, Shelley Levine, and Linda Streit.

Within the Division of Mental Health Services, John Callahan, Frank Noyes, John Ogonik, and Joe Peck provided useful quantitative and qualitative background information. Outside of the Department, Nancy Caracciola, Dorothy Mooney and Margaret Zirker gave their time as well as their data.

In addition to OSTMPD staff, several others slogged their way through an early draft of the report and were even willing to talk about it afterward; they are Jim Divver, Cathy Dunham, Camie Hertz, John Lichten, Phyllis Oram, David Specht, Marylou Sudders and Jack Sullivan. Melissa Shaak checked the numbers for all of the Appendix E tables. During the revision process, Kathy Durkin was particularly helpful with Report II. Tom Coleman functioned as an informal consultant during the design and data analysis stages of the research and Camie Hertz did so throughout the entire study.

Most of all, the respondents of this study deserve recognition. Because they were offered anonymity their names are not listed here. However, the extent to which their generous cooperation with the researchers made this study possible cannot be overstated.

Elizabeth N. Rosenthal
Project Director

APPENDIX A: TITLE XIX

Title XIX of the Social Security Act, the Medicaid program, was enacted in 1965. It authorized grants to states for medical assistance to low income persons who are age 65 or over, blind, or disabled, or who are members of families with dependent children. The program is jointly financed by the federal and state governments, and is administered by states.

In Massachusetts, the Department of Public Welfare (DPW) is authorized as the state agency responsible for determining Title XIX eligibility. DPW acts as a fiscal agent and has contracted the Department of Public Health (DPH) to perform the actual certification surveys for compliance with federal regulations. All facilities participating in or seeking to participate in the Title XIX program must be certified in order to receive federal funding. Certification of state psychiatric hospitals by DPH signifies that a certain number of beds in a unit or ward of a hospital are in compliance with the conditions of participation for Medicaid certification.

The fiscal impact of certification (or decertification) upon the DMH-operated hospitals discussed in this report is illustrated in Figure 1, below. Projected federal financial participation is 53.75% of the daily per capita rate.

Figure 1. Total Number of Certified Beds in DMH-Operated Hospitals; Certified Patients and Daily Per Capita Rate, FY'82

Hospital	Certified Beds	Certified Patients	Daily Per Capita Rate	Projected Federal Financial Participation, FY'83
Danvers	0	0	114.81	0
Metropolitan	63	29	107.63	612,354.00
Taunton	25-Brockton Unit	7	198.94	273,206.00
	90-New Bedford Unit	22		858,650.00
	45-PAT Unit	19		741,561.00
Worcester	162	73	139.97	2,004,607.00

For further information on Medicaid regulations, consult Chapter IV of Title 42, Code of Federal Regulations, or contact the Health Care Financing Administration, Department of Health and Human Services, Washington, D.C.

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH:

OFFICE OF STAFF TRAINING, MANPOWER PLANNING AND DEVELOPMENT

STATE HOSPITAL WORKFORCE MANAGEMENT PROJECT

STUDY NUMBER 1

Report I: Department of Mental Health Psychiatric Hospitals: Recruitment

December, 1982

Elizabeth N. Rosenthal
Project Director

DMH PSYCHIATRIC HOSPITALS: RECRUITMENT

INTRODUCTION

The report that follows presents data on the recruitment of nursing staff at psychiatric hospitals operated by the Massachusetts Department of Mental Health. This is the first in a series of reports that resulted from a study of recruitment-related aspects of psychiatric hospital workforce management. The study was conducted between April and August, 1982, by staff of the Office of Staff Training, Manpower Planning and Development, a unit within the Central Office of the Massachusetts Department of Mental Health.

BACKGROUND

The Massachusetts Department of Mental Health (DMH) presently operates nine state hospitals that provide mental health, medical and rehabilitative services to mentally ill persons requiring inpatient care.[1] In addition, DMH has under its jurisdiction the Bridgewater Treatment Center for Sexually Dangerous Persons. DMH is responsible for the programmatic aspects of the Center's functions, while the Commissioner of Corrections retains responsibility for the administration and operation of the Center.

Two of the state hospitals, Cushing and Gaebler Children's Center, are defined by the types of patients served (i.e., geriatric and children/adolescents) without regard to the geographical areas from which these patients come. Each of the remaining

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[1] Another institutional facility, Boston State Hospital, houses other psychiatric programs but no longer is operated as a state hospital.

DMH-operated hospitals (Danvers, Medfield, Metropolitan, Northampton, Taunton, Westboro and Worcester) is organized into multiple inpatient units corresponding to DMH geographical catchment areas served by the hospital.[2] Accordingly, each unit is to provide inpatient services specifically to patients from the DMH catchment area with which that unit is associated. Each director is hired by and reports to the Area Director of the respective catchment area.

METHODOLOGY

Site Selection

For the purposes of the present study, four DMH-operated hospitals (Danvers, Metropolitan, Taunton and Worcester) were selected as project sites. Eight inpatient units, two at each of the four hospitals, made up the study sample. Within the sample there were variations from the unitized organization presented in the "Background" section of this report. Certain inpatient units of these hospitals have come to serve a specific type of patient rather than all patients of a geographical catchment area. Responsibilities and reporting relations now differ among these units. For example, at three of the selected hospitals one unit provides inpatient services to geriatric patients who come from any catchment area served by that hospital. The New Bedford Unit at Taunton State Hospital provides inpatient

[2] During the design and implementation of this project in FY'82, the catchment areas (of which there are forty) were organized into four districts, each under an assistant deputy commissioner. In FY'83 these district boundaries were changed to seven such districts, each managed by a district manager.

services for any geriatric patient served by the hospital, but administratively it is organized as a DMH area inpatient unit, with a unit director hired by and reporting to the New Bedford area director. The Geriatric Unit of Metropolitan State Hospital has comparable service responsibility, but its current director, although similarly hired by and reporting to the Mystic Valley area director, is called a program director and is in a lower personnel position than that of other unit directors. At Worcester State Hospital, geriatric services and other functional services are provided by one unit, Regional Services. Here, a unit manager reports to a unit director who also has other responsibilities at the hospital and who reports directly to the district manager.

In response to the hypothesis of DMH executive staff that the client population in geriatric units differs from the general inpatient population in ways that affect recruitment and retention of unit staff, geriatric and non-geriatric units were selected for study. It was hypothesized that patients in geriatric units would require relatively more medical nursing care and less psychiatric care than would non-geriatric inpatients, and that these differences in the functional jobs required of nursing staff would result in the attraction and retention of different kinds of staff. It was predicted that these differences would manifest themselves as differences in employment patterns between geriatric and non-geriatric units.

The following Table presents the project sites and relevant descriptive information.

Table 1

Project Sites

Hospital	Unit	Catchment Area Affiliation	District Affiliation[3]
Danvers State	Haverhill/Newburyport Lynn	Haverhill/Newburyport, Lynn	III
Metropolitan State	Geriatric * Tri-City	Tri-City **	IVA
Taunton State	Brockton New Bedford *	Brockton New Bedford	V
Worcester State	North Central Regional Services/ Geriatric*	Fitchburg/Leominster Gardner/Rutland	II

* Geriatric units serving several catchment areas within a district.
** The three cities are Malden, Medford and Everett.

Data Collection

Each of the eight units selected was the subject of two formal research activities. The first effort, focused on the recruitment of nursing staff, involved conducting structured interviews with those individuals currently responsible for recruiting

[3] Districts reported are current (FY'83)

staff to the selected inpatient units. A description of the methodology and findings of this activity comprises the remainder of this report. The second research activity entailed the collection and analysis of pertinent data from nursing staff personnel records. These inquiries and their results are presented in a subsequent report, "DMH Psychiatric Hospitals: Employment Trends."

Structured interviews were conducted with individuals identified by unit directors as having primary responsibility for recruiting nursing and other clinical staff to the inpatient units. Because this recruitment responsibility is handled differently at the different units studied, the number of individuals interviewed for each unit varied from one to three. At each unit this included one or more of the following: the unit director, the unit manager, the director of nursing, the personnel director of the affiliated catchment area.[4] In cases where more than one individual at a unit was interviewed, only one "unit response" is reported. Where respondents from a unit did not reconcile differing opinions during the interview, responses of the individual originally identified by the relevant Associate District Commissioner or Area Director as the "key recruitment person" are reported.

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[4] In a number of instances these were the functional (i.e., derived from the functions of the job itself rather than from the formal job description), but not the civil service position titles of the individuals who were interviewed. (See Appendix B, "In-house job descriptions.")

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The structured interview form was developed collaboratively by a team of DMH Central Office manpower staff and consultants and was reviewed by DMH executive staff prior to being tested in the field. To ensure consistency in data collection, one interviewer conducted all of the structured interviews. These interviews were conducted between May 24 and June 11, 1982.

The structured interview was extensive and generally required two hours to administer. While qualifying comments were welcomed, most questions were designed as closed with specified rating or response-categories to permit quantification of the data. The interviews focused on the recruitment of licensed nurses, including both registered nurses (RNs) and licensed practical nurses (LPNs), and also of unlicensed mental health assistants (MHAs). Information was sought regarding: current recruitment practices; perceived effectiveness of these practices; extent and use of resources for recruitment;and perceived constraints upon recruitment, including incentives and disincentives to potential employees.

FINDINGS

The following is a summary of findings about nursing staff recruitment practices from structured interviews of key respondents at eight inpatient units of hospitals operated by the Massachusetts Department of Mental Health.

Recruitment Responsibilities

Recruitment of licensed and unlicensed nursing staff to inpatient units appears to be treated as a low priority function, with no

planning component. Interviews revealed that it is done on a unit by unit basis, without coordination either among units or among hospitals.

- All individuals interviewed characterized recruitment as an "as needed" rather than as an "ongoing" activity. They all indicated that recruitment activities represented less than forty percent of a full-time equivalent staff member's job; three-quarters of the respondents felt that these activities were less than twenty percent of a full-time equivalent staff member's job.

- Respondents indicated that they generally do not receive much notice before a staff vacancy occurs. Respondents of six units typically receive two to four weeks notice; at the other two units generally less than two weeks is given.[5]

- All respondents included screening and interviewing in their working definitions of staff recruitment. However, individuals had varying degrees of authority, responsibility and autonomy in recruitment-related advertising and hiring decisions.

- Recruitment for nursing staff generally is done by the unit director and/or the director of nursing. Unit directors who are RNs (half of the

[5] A minimum of two weeks notice commonly is requested, but some respondents found it unrealistic to expect MHAs to comply.

sample) have more direct involvement in nursing staff recruitment than those who are not PNs.[6]

Recruiter Qualifications

The interviews revealed that recruitment is performed as an ancillary assignment by individuals with other primary jobs. These individuals are generally untrained as recruiters.

- None of those interviewed was hired solely or even primarily to be a recruiter. Half reported understanding when hired that recruitment was an integral part of the job. Even fewer were under the impression that recruitment is included in their current job descriptions. (See Appendix B.)

- Two of the eight respondents had prior recruitment experience in similar staff positions at DMH-operated hospitals. Two other respondents said they had received formal recruitment-related training; however, further questioning revealed that this training was very limited.

Recruitment Methods

Respondents were asked to identify the recruitment methods they use to attract new staff to the hospital. They were then asked to characterize these methods as "not at all effective," "somewhat effective" or "effective." The data suggest that the ex-

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[6] See Table 2, "Formal Education of Unit Directors," in Appendix C.

tent to which a recruitment strategy is considered effective is directly correlated with the frequency of its use and inversely correlated with its budgeted cost: those interviewed consider the apparently low cost, frequently used strategy of recruiting current DMH employees from elsewhere in the hospital to be most effective.

- Use of personal contacts of current employees was cited by all respondents as both the most frequently employed and the most effective strategy for external recruitment of new staff; this was the one recruitment method that all units employed.

- Newspaper advertising was used as an effective or somewhat effective current recruitment practice by three quarters of the respondents.

- Contacts with professional schools was characterized as somewhat or not at all effective by those who currently use them.

- Referrals from public sector employment and training agencies (e.g., Department of Employment Security, Department of Personnel Administration) generally were not considered effective.

- Other recruitment methods that had been tried or were under consideration included use of professional publications, radio and television.

Application of these methods was erratic and they generally were regarded as either not effective or of undetermined effectiveness.

- One unit effectively recruited retired RNs, formerly employed at the hospital, to work on a time-limited basis. The respondent believed that this recruitment method had ancillary benefits in that these retirees do not require orientation and frequently are willing to work weekends and other unpopular shifts (i.e., nights and holidays).

Recruitment Constraints

The uncertain lifespan and poor image of the hospitals were cited as key reputation-related constraints on successful recruitment. Additional operational constraints identified by respondents included the lack of systematically budgeted monies to support recruitment activities and the cumbersome nature of required administrative procedures.

- Based on a list of categories provided in the structured interview, the image of the system was identified as the most serious barrier to filling licensed nursing positions. Contributing to this negative image, the uncertain lifespan of DMH hospitals was identified by several respondents as a major obstacle to successful recruitment.

- Recruitment activities generally seemed to be very much constrained by lack of funds. Half of those interviewed reported that in FY'82 they had no monies specifically budgeted for recruiting. Of those who did report having funds for recruitment in FY'82, all but one respondent indicated that these funds were provided solely by the Area Directors; such allotments are discretionary.[7]

- Required internal recruitment procedures were relied upon by all units, and some respondents cited this as their primary method of filling vacant positions. However, these procedures were found to be complex and time-consuming, and some respondents viewed them as a potential barrier to obtaining the best person for the job.[8]

- Other factors cited by respondents as obstacles to successful recruiting included shortage of applicants, local competition and image of patient population. Factors also cited but ranked

[7] One respondent reported that the hospital had a recruitment budget of $2,000 in FY'82, of which this unit received a small portion. The respondent of the other unit studied at this hospital reported no budget allotment for recruitment during FY'82, and apparently was not aware of the existence of hospital recruitment monies.

[8] See Appendix D for further discussion of internal recruitment.

of lesser importance were low salary, inadequate benefits, working conditions and lack of public transportation.[9]

- Inadequacies in benefits that were viewed as recruitment constraints included lack of tuition reimbursement, inadequate staff development, lack of flex-time and poor shift differentials.[10] (Retirement and medical benefits were cited as facilitating recruitment.)

Recruitment Results

According to interview data, licensed nursing staff are more difficult to recruit than are unlicensed staff.

- Difficulty in recruiting nursing staff to DMH-operated hospitals varied, with recruitment of RNs generally reported as very difficult, of LPNs as difficult and of MHAs as not difficult.[11]

- Respondents varied in the extent to which they considered recruitment of LPNs to be a problem.[12]

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[9] It should be noted that there was a wide spread of ratings for some of these items.

[10] A shift differential is the fixed increase to the regular salary paid to an eligible employee who works a less desirable shift.

[11] Table 3, which provides the mean and range of each category of responses, can be found in Appendix C.

[12] While recruitment of LPNs was considered difficult, some respondents saw this as a less serious problem than recruitment of RNs because they viewed LPNs as functionally comparable to MHAs. A contrary view also expressed was that recruitment of LPNs is of particular concern because they are capable of functioning on a par with RNs, but have a lower entry salary, virtually no career ladder and less organizational clout.

Orientation

Interview data revealed that hospital-wide orientation programs either are not in place or are not effective.

- Newly hired nursing staff theoretically participate in a hospital-wide orientation program as well as in orientation activities within their own units; however, half of the respondents indicated that no formal hospital-wide orientation is provided. Other respondents cited problems with existing hospital-wide orientation programs, indicating that the programs were too general to be useful or that they were unattended due to inadequate staff coverage on the ward.

- Unit orientation programs currently in use commonly were reported to include one to two weeks during which the new staff member is paired with a peer under the responsibility of the unit's functional director of nursing.

APPENDIX B: DMH PSYCHIATRIC HOSPITALS, IN-HOUSE JOB DESCRIPTIONS

During the course of the study, it was frequently found that civil service job titles and descriptions did not match the actual work being performed by individuals at the inpatient units. There are two principle reasons for this discrepancy.

First, economic factors (e.g., inflation) overtook the cost-of-living increases built into the salary schedules, so that salary levels became increasingly uncompetitive with those of apparently comparable jobs in the private sector.

Second, there has been a shift in the organizational structure of the hospitals to a unit-based operation. Consequently, individual jobs within the hospital also would need to change, in order to be compatible with these organizational changes.

Faced with the prospect of a slow and therefore insufficiently responsive civil service reclassification and salary schedule restructuring process, two interim management strategies were developed. One strategy was to hire employees into positions that, on paper, were at a higher level than the actual job required, and therefore were at a correspondingly higher and more competitive salary. The other was to develop functional job descriptions for use "in house."

Functional job descriptions have been put into writing at several of the inpatient units studied and are kept current according to

interviewed respondents. It is these "in-house" job descriptions, unlike their official civil service counterparts, that refer to recruitment responsibilities.

APPENDIX C: DMH PSYCHIATRIC HOSPITALS

TABLE 2

FORMAL EDUCATION OF UNIT DIRECTORS AT EIGHT INPATIENT UNITS

	DANVERS		METROPOLITAN		TAUNTON		WORCESTER	
	Lynn	Haverhill Newburyport	Geriatric	Tri-City	Brockton	New Bedford	Regional Geriatric	North Central
RN	X		X		X	X		
BA/BS	X	X		X	X	X	X	X
Masters		X		X	X		X	X
Post Masters		X		X				
Ph.D.							X	X

TABLE 3

DIFFICULTY IN RECRUITING NURSING STAFF TO DMI-OPERATED HOSPITALS, ACCORDING TO RESPONDENTS AT EIGHT INPATIENT UNITS

	mean	range
RN	4.6	3 - 5
LPN	4.4	2 - 5
MHA	1.8	1 - 4

Ratings were derived as responses to the question: On a scale from 1 to 5, where 1 = not as all difficult and 5 = very difficult, rate the following positions according to the degree of difficulty in filling them: RNs, LPNs, MHAs.

APPENDIX D: DMH PSYCHIATRIC HOSPITALS, INTERNAL RECRUITMENT

Collective bargaining agreements and Civil Service regulations, as well as constraints in budgetary support for external recruitment, are incentives for "hiring from within." In many cases, the procedures for internal recruitment must precede formal external recruiting efforts. According to these procedures, all requests to post or announce vacancies are to be submitted in writing to the relevant personnal office.[1] Upon receipt of such a request, the personnel office notifies the unit submitting the request of the status of the position (i.e., whether or not it is funded) and of the approximate date of appointment (i.e., the date on which it can in fact be filled). The personnel office then posts the vacancy in accordance with the relevant collective bargaining agreements and/or Civil Service regulations.

Views of Respondents at Eight Inpatient Units

Recruitment of licensed nurses by one inpatient unit from another unit of the same hospital is common and frequently was referred to by respondents in this study as "stealing."

Respondents' attitudes about required internal recruitment procedures varied. Some support the preference of in-house candidates, others indicated that in this business the ability to dissuade an applicant from pursuing a position was a valuable interviewing

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[1] A description of the personnel offices used by the inpatient units in this study appears in "DMH Psychiatric Hospitals: Employment Trends," Section II of this report.

skill. One respondent reported having given up a position rather than being forced to hire an unsatisfactory staff member into it.

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH:

OFFICE OF STAFF TRAINING, MANPOWER PLANNING AND DEVELOPMENT

STATE HOSPITAL WORKFORCE MANAGEMENT PROJECT

STUDY NUMBER 1

Report II: Department of Mental Health Psychiatric Hospitals: Employment Patterns

December, 1982

Elizabeth N. Rosenthal
Project Director

DMH PSYCHIATRIC HOSPITALS: EMPLOYMENT PATTERNS

INTRODUCTION

The report that follows presents data on employment patterns of nursing staff at psychiatric hospitals operated by the Massachusetts Department of Mental Health (DMH). This is the second in a series of reports that resulted from a study of recruitment-related aspects of psychiatric hospital workforce management. The study was conducted between April and August, 1982 by staff of the Office of Staff Training, Manpower Planning and Development, a unit within the Central Office of the Massachusetts Department of Mental Health.

BACKGROUND

The intent of the research effort presented in this report was to obtain from personnel records information on employment patterns of licensed and unlicensed nursing staff at DMH-operated psychiatric hospitals. This was an exploratory effort designed to supplement findings gleaned from interviews with individuals responsible for recruiting nursing staff to selected inpatient units of these hospitals.[1]

Organization of the Personnel Function

The Massachusetts Department of Mental Health presently is structured as a decentralized system of geographical catchment areas which are organized into districts and through which mental health and mental retardation services are provided to citizens of the

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[1] A description of the methodology and findings of that research activity are presented in Report I, "DMH Psychiatric Hospitals:

Commonwealth.[2] The State Legislature has ultimate authority for establishing rosters of personnel positions and for assigning some of these to DMH.[3] Prior to the establishment of a decentralized system, most personnel paperwork for DMH employees was handled by the Office of Personnel within the Department's Central Office. Only psychiatric hospitals and mental retardation facilities operated by the Department, while accountable to Central Office, managed their own appropriations and ran their own personnel offices.

The enactment of Chapter 735 of the General Laws, in 1966, established regions within the Department.[4] At the outset, the regions lacked the capacity to manage their own personnel paperwork. In some cases, preparation of personnel forms was taken over by the personnel office of a DMH-operated psychiatric hospital or mental retardation facility located within the region; in other cases, the Department's Central Office continued to perform this function, as well as retaining formal responsibility for maintenance of personnel records.

In 1977, regional business offices were established.[5] Some of these were located at the site of the institutional business offices

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[2] During the design and implementation of this study in FY'82, the catchment areas (of which there are forty) were organized into four districts, each under an assistant deputy commissioner. In FY'83, these district boundaries were changed to seven such districts, each managed by a district manager.

[3] At the end of FY'82, there were 21,787 authorized personnel positions on record as having been assigned to DMH.

[4] The districts initially were called regions; services within each region were under the administration of a regional services administrator.

[5] These are now called service bureaus.

previously mentioned; others had separate locations. In addition, area allocation accounts subsequently were set up in some regions, and some area personnel offices were established. As a decentralized personnel capacity developed, the role of the Office of Personnel within the Department's Central Office changed; at present this office performs the personnel function for Central Office employees, continues to handle the personnel paperwork for two catchment areas and provides technical assistance to the field.

METHODOLOGY

Site Selection

Data were gathered from personnel records of nursing staff at eight inpatient units, two at each of four psychiatric hospitals operated by the Department. The following Table presents the research sites and relevant descriptive information.

TABLE 4

Research Sites

spital	Unit	District and Catchment Area Affiliation	Location of Unit Personnel Records
s State	Haverhill/Newburyport	III: Haverhill/Newburyport	Danvers State Hospital: Service Bureau
	Lynn	III: Lynn	
olitan ce	Geriatrics*	IVA: (Serving All Areas)	Metropolitan State Hospital: Personnel Office
	Tri-City**	IVA: Tri-City	
n State	Brockton	V: Brockton	Brockton Area Personnel Office
	New Bedford*	V: New Bedford (Serving All Areas)	Taunton State Hospital: Personnel Office
ter e	North Charles	II: Fitchburg/Leominster, Gardner/Rutland	Glavin Regional Center: Service Bureau Worcester State Hospital: Personnel Office
	Regional Services Geriatrics*	II: (Serving All Areas)	Worcester State Hospital: Personnel Office

tric units serving several catchment areas within a district.
three cities are Everett, Maldon and Medford.

Based on the hypothesis that differences in the functional jobs required of nursing staff at geriatric units would result in the attraction and retention of different kinds of staff to these units, it was predicted that different employment patterns would be found at these two types of units. Another hypothesis was that recruitment of licensed nurses, difficult at all DMH-operated units, would result in the use of unlicensed mental health assistants "in lieu" of licensed nursing staff.[6]

Data Collection

For each of the eight inpatient units, the following data were gathered on registered nurses (RNs), licensed practical nurses (LPNs) and unlicensed mental health workers (MHAs):

- Number of funded positions in FY'82 specified as vacant, filled or filled "in lieu"
- Number of new hires in FY'82
- Number of terminations in FY'82
- For those still employed, length of employment in the current position and cumulative employment within the system
- For those terminated in FY'82, length of employment in the most recently held position and cumulative employment within the system
- Number of those terminated in FY'82 who moved to another position within the system

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[6] "In lieu" hiring: the substitution of one position of an equal or lower grade for another, usually for a specified period of time (e.g. mental health assistant "in lieu" of staff nurse).

Initially, longitudinal as well as current fiscal year data were sought. However, preliminary data gathering efforts revealed that changes in hospital organization and in personnel record-keeping procedures rendered problematic the comparison of data from different fiscal years.[7] Therefore, this research effort was limited to the collection and analysis of data about employees filling (and vacating) positions in the selected units during all or part of FY'82.

The FY'82 personnel data presented in this report were gathered during June, 1982. In order to ensure comparability across sites, the data collected were those recorded for the period up to June 1, 1982. Since the state's fiscal year runs from July 1 to June 30, these FY'82 data actually fall one month shy of covering the full fiscal year.

The section that follows explains the use of these data to determine employment patterns.

Data Analysis

The data were analyzed to determine turnover rates, quick turnover rates, internal turnover rates, length and frequency of vacancies, length of employment and nursing staff-to-patient ratios. Unless otherwise indicated, the mean (average) was used as the measure of central tendency. Comparisons were made between registered nurses (RNs) and licensed practical nurses (LPNs), between licensed and unlicensed nursing staff, among hospital units and between geriatric

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[7] Personnel records must be maintained according to requirements of the Department of Personnel Administration, of Equal Employment Opportunity and of union contracts.

and nongeriatric units. A brief explanation of the formulas used in the analysis follows. In all cases rates are percentages obtained by multiplying the ratios by 100.

Turnover Rate

The rate of turnover is recognized as one measure of an organization's ability to retain its employees. Traditionally, rate of turnover has been defined to be the number of terminations (X) as a percentage of the average workforce (Figure 1).[8]

Figure 1

$$\left(\frac{X}{\text{average workforce}} \right) 100$$

Because data with which to compute average workforce were not available for all inpatient units, a surrogate measure, i.e., currently filled positions, was substituted in the denominator of this formula. For each unit and each position category (RN,LPN,MHA), this measure utilized the number of positions recorded by personnel as filled as of June 1, 1982. Thus, turnover rate is the number of terminations (X) as a percentage of currently filled positions as of 6/1/82 (Figure 2).

Figure 2

$$\left(\frac{X}{\text{currently filled positions, 6/1/82}} \right) 100$$

As noted elsewhere in this report, number of terminations appears as the number of employees (including full-time and part-time staff)

[8] For a thoughtful explication of the methodology and utility of this formula, see T.E. Coleman, An Investigation of Staff Turnover at Five Massachusetts Retardation Facilities, 1980. On file at the Massachusetts Department of Mental Health, Central Office.

who terminated between July 1, 1981 and June 1, 1982.[9] The numerator of this formula, therefore, is somewhat larger than if full-time equivalent terminations were reported, thus inflating the overall turnover rates reported. The reported rates more accurately reflect the rate of changing staff than would turnover rates calculated using the number of full-time equivalent terminations.

Quick Turnover Rate

Quick turnover rate is defined as an indicator of the organization's ability to retain recently hired staff. A high quick turnover rate would suggest that current recruitment practices do not include successful techniques for screening out applicants who are likely to leave and/or that the organization currently does not provide effective retention incentives. Quick turnover rate is defined to be the number of staff who worked less than one year and terminated, as a percentage of the number of new hires during that same time period (Figure 3).

Figure 3

$$\left(\frac{\text{number of terminated who worked} \leq 1 \text{ year up to } 6/1/82}{\text{number of new hires between } 7/1/81 \text{ and } 6/1/82} \right) 100$$

For each unit and each position category (RN, LPN, MHA), this measure utilized the number of positions on record as filled as of June 1, 1982.

Internal Turnover Rate

The internal turnover rate provides a measure of employee mobility

[9] See "Notes to Tables 11-41" Appendix E.

within the DMH system. Of those who terminate from a nursing staff position on one unit, a certain number move to another position within the system -- perhaps within another unit, perhaps within the community.[10] Specifically, the internal turnover rates presented in this report give some indication of the extent to which nursing staff positions at the selected inpatient units have generated staff for the mental health system.

Rate of Vacancy

This measure provides an indication of the gap between "perfect" and actual recruitment efforts. Vacancies are defined as times during a specified period that positions are left fully or partly vacant.[11] (A partial vacancy occurs when a part time employee is hired into a full time position.) Number of vacancies in conjunction with the number of new hires for the period[12] can be viewed as a measure of recruitment demand.

Length of Vacancy

At each of the sites the lengths of nursing staff vacancies during the period between July 1, 1981 and June 1, 1982 were reviewed and compared to the lengths of those still vacant on June 1, 1982.

Length of Employment

For all nursing staff employed during FY'82, length of employment in the position most recently held was reviewed and analyzed. This

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[10] See Appendix E, Table 38, "Terminations by Type of Termination."

[11] "Number of Vacancies: All Nursing Staff FY'82" appears as Table 12 in Appendix E.

[12] "Number of New Hires: All Nursing Staff FY'82" appears as Table 15 in Appendix E.

was the current position of those still employed, and the most recent position of those who terminated during the year.

Nursing Staff-to-Patient Ratios

The theoretical nursing staff-to-patient ratios (i.e., the number of funded nursing staff positions to the number of available beds) and the actual nursing staff-to-patient ratios (i.e., the number of full-time-equivalent nursing staff currently employed to the current number of patients) were compared across the units, and also with data on actual nursing staff-to-patient ratios in general hospitals in Massachusetts.[13]

FINDINGS

The following is a summary of findings about employment patterns of nursing staff derived from personnel records at eight inpatient units of four hospitals operated by the Massachusetts Department of Mental Health. Nursing staff includes licensed nurses, who are either registered nurses (RNs) or licensed practical nurses (LPNs), and unlicensed mental health assistants (MHAs).

Findings are categorized as follows: turnover rate, quick turnover rate, internal turnover rate, vacancies, length of employment and staff to patient ratios. It should be recalled that these findings are all based on FY'82 data recorded for the period up to June 1, 1982. Therefore they are findings for an eleven month period. Per-

[13] From Mooney, D.A. and Zirker, M.E., General Hospital Psychiatry in Massachusetts: A Mental Health Project of the Massachusetts Hospital Association and the Department of Mental Health, Burlington, MA, 1981.

centages have been rounded off to the nearest whole number in the text and tables of this report; more precise calculations appear in the appendices.

Turnover Rate

Turnover rate has been defined as a measure of the organization's ability to retain its employees.[14] Findings are summarized in Table 5 below and appear in further detail in Appendix E, Tables 17-21.[15]

Table 5

Turnover Rate* of Nursing Staff**, FY'82

	RN	LPN	MHA	Total Nursing Staff
Geriatric Units	56	20	17	24
Non-Geriatric Units	51	48	63	57
Total Units	53	36	40	41

*Calculated as: $\left(\frac{\text{number of terminations as of 6/1/82}}{\text{number of currently filled positions}}\right)100$

**Layoffs, not included:

Lynn - 1 licensed staff, 2 unlicensed staff
Brockton - 3 unlicensed staff
New Bedford - 1 licensed staff, 4 unlicensed staff

- For the eight inpatient units studied, the turnover rate among licensed nurses (RNs and LPNs) and unlicensed nursing staff (MHAs) in FY'82 is 41%.

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[14] For a more detailed discussion, see the "Methodology" section of this report.

[15] The turnover rates reported for FY'82 are conservative since they include only eleven months of data on terminations.

- Among licensed and unlicensed nursing staff, registered nurses (RNs) have the highest turnover rate (53%) and licensed practical nurses (LPNs) the lowest (36%).

- The turnover rate among nursing staff of non-geriatric units (57%) is notably higher than that of geriatric units (24%). The difference in turnover rates between non-geriatric and geriatric units is accounted for primarily by turnover of unlicensed nursing staff (63% in non-geriatric as compared with 17% in geriatric units), and secondarily by turnover of LPNs (48% in non-geriatric as compared with 20% in geriatric units). By contrast, among RNs the turnover rate in geriatric units (56%) is slightly higher than in non-geriatric units (51%).

Quick Turnover Rate

Quick turnover rate has been defined as an indicator of the organization's ability to retain recently hired staff.[16] Findings are summarized in Table 6 below and appear in further detail in Appendix E, Table 22.[17]

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[16] For a more detailed discussion, see the "Methodology" section of this report.

[17] The quick turnover rates are conservative since they include only eleven months of data on terminations.

Table 6

Quick Turnover Rate* of Nursing Staff**, FY'82

	Licensed Staff	MHA	Total Nursing Staff
Geriatric Units	84	34	53
Non-Geriatric Units	56	74	66
Total Units	63	63	63

*Calculated as: $\left(\frac{\text{number terminated who worked} \leq 1 \text{ year as of } 6/1/82}{\text{number of new hires as of } 6/1/82}\right)100$

** Layoffs, not included:

Lynn - 1 licensed staff, 2 unlicensed staff
Brockton - 3 unlicensed staff
New Bedford - 1 licensed staff, 4 unlicensed staff

- For the eight inpatient units studied, the quick turnover rate among licensed and unlicensed nursing staff in FY'82 is 63%, notably higher than the comparable turnover rate discussed above.

- The difference in quick turnover rates between licensed (62.5%) and unlicensed nursing staff (62.8%) is negligible.

- When quick turnover rates of licensed and unlicensed nursing staff are compared across geriatric and non-geriatric units, a "criss-cross" pattern emerges. While the quick turnover rate of licensed nursing staff in geriatric units (84%) is notably higher than that of unlicensed staff in these units (34%), in non-geriatric units

the reverse is true: there the quick turnover rate of licensed nursing staff (56%) is lower than the quick turnover rate of unlicensed nursing staff (74%).

Internal Turnover Rate

Internal turnover rate has been defined as a measure of employee mobility within the DMH system.[18] Findings are summarized in Table 7 below and appear in further detail in Appendix E, Table 23.[19]

Table 7

Internal Turnover Rate*, FY'82

	RN	LPN	MHA	Total Nursing Staff
Geriatric Units	21	2	1	5
Non-Geriatric Units	6	16	16	14
Total Units	12	9	9	10

*Calculated as: $\frac{\text{number terminated, FY'82, who moved to another position within DMH System}}{\text{number of currently filled positions as of 6/1/82}}$ 100

Terminations include part-time employees; currently filled positions are full-time or full-time equivalents.

- For the eight inpatient units studied, the internal turnover rate for licensed and unlicensed nursing staff is 10%.

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[18] For a more detailed discussion, see the Methodology section of this report.

[19] The internal turnover rates reported for FY'82 are conservative since they include only eleven months of data on terminations.

Vacancies

Vacancies have been defined as times during a specified period that positions were left fully or partly vacant. Length of vacancy is calculated in months.[20] Findings are summarized in Table 8 below and appear in further detail in Appendix E, Tables 24-26.

Table 8

Average Length (in months) of Nursing Staff Vacancies*, FY'82

	RN	LPN	MHA
Geriatric Units	1.3	3.4	1.8
Non-Geriatric Units	3.4	1.2	1.8
Total Units	2.8	1.6	1.8

*Vacancies are the number of times between July 1, 1981 and June 1, 1982 that positions were left fully or partly vacant.

- Among the eight inpatient units studied, the average length of all nursing staff vacancies is approximately two months, with relatively little difference between licensed and unlicensed nursing staff positions.

- Within each position category, the average length of vacancy is comparable between geriatric and non-geriatric units.

- Average length of current vacancies (i.e., fully and partly vacant positions as of 6/1/82) is notably greater than is the average

[20] For a more detailed discussion, see the "Methodology" section of this report.

length of overall vacancies, with current vacancies in LPN and MHA positions lasting an average of 13 months, and in RN positions averaging nearly nine months.

- For all nursing staff (RNs, LPNs, and MHAs), length of current vacancies is greater in geriatric than in non-geriatric units.

Length of Employment

For the licensed and unlicensed nursing staff employed during FY'82, length of employment was determined for the position most recently held.[21] Findings are summarized in Table 9 below and appear in further detail in Appendix E, Tables 27-35.[22]

Table 9

Median Length* of Employment (in years) of Nursing Staff, FY'82

	RNs		LPNs		MHAs		Total Nursing Staff	
	N	Years	N	Years	N	Years	N	Years
ric Units	63	2-3	60	9-10	194	3-4	317	3-4
eriatric s	77	<1	52	4-5	286	1-2	415	1-2
Units	140	1-2	112	7-8	480	1-2	732	1-2

*The median length corresponds to the middle case when all individual cases are arranged in order of length of employment.

- At the eight inpatient units studied, nursing staff tended to have been

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[21] For a more detailed discussion see the "Methodology" section of this report.

[22] Because of the skewed distribution of length of employment of nursing staff, it was determined that the median would be a better measure of central tendency than would the mean. For a more detailed discussion, see the "Methodology" section of this report.

employed in these positions for between one and two years, with a range from less than one year to more than twenty-five years. Slightly more than half of the sample (52%) had held positions for under two years. The median and range in length of employment were roughly comparable for licensed and unlicensed staff.

- Among licensed nurses, LPNs tended to have held their positions for considerably longer than had RNs. Fewer than half of the RNs (46%) had been on the job for two years or more, but more than three quarters of the LPNs (78%) had worked for at least two years.

- Both licensed and unlicensed nursing staff employed in geriatric units tended to have held their positions longer than those employed in non-geriatric units.

- On average, licensed and unlicensed nursing staff who terminated during FY'82 held their positions for less than one half as long as those still employed. However, the difference in length in position between formerly employed and currently employed RNs does not appear to be significant. By contrast, the difference is pronounced for LPNs: those still employed had worked an average of five and one half times as long as those who had left their positions.

Nursing Staff-to-Patient Ratios

The theoretical and actual nursing staff-to-patient ratios were compared across units, and also with data on actual nursing staff-

to-patient ratios for psychiatric patients in general hospitals in Massachusetts.[24,25] Findings are summarized in Table 10 below and appear in further detail in Appendix E, Tables 40,41.

Table 10

Average Public and Private Sector Staff/Patient Ratios for Licensed, Unlicensed and all Nursing Staff

Public Sector Study Sample		
Theoretical Ratios*	Mean	Range
Theoretical Licensed Nurse/Patient Ratio	.46:1	.29:1-.74:1
Theoretical MHA/ Patient Ratio	.65:1	.48:1-1.13:1
Theoretical Nursing Staff/Patient Ratio	1.11:1	.95:1-1.42:1
Actual Ratios **		
Actual Licensed Nurse/Patient Ratio	.33:1	.15:1-.51:1
Actual MHA/Patient Ratio	.68:1	.39:1-1.04:1
Actual Nursing Staff/Patient Ratio	1.00:1	.69:1-1.19:1
Private Sector Study Sample		
	Mean	Range
Actual Licensed Nurse/Patient Ratio	.68:1	.44:1-1.11:1
Actual Mental Health Worker/Patient Ratio	.45:1	.29:1-.73:1
Actual Nursing Staff/Patient Ratio	1.13:1	.73:1-1.85:1

* Theoretical ratios are computed as the total number of funded positions divided by the total number of beds

** Actual ratios are computed as the total number of FTE inpatient staff divided by the total number of patients

[24] In the general hospitals, nursing staff comprise an average of 78% of direct care staff.

[25] For a more detailed discussion, see the "Methodology" section of this report.

- Among DMH-operated inpatient units, the average theoretical nursing staff-to-patient ratio was 1.11:1, with a range from .95:1 to 1.42:1.
- Among these same units, the average actual ratio was 1.00:1, with a range from .69:1 to 1.19:1.
- Overall, it appears that nursing staff-to-patient ratios of the DMH-operated units are closer than expected to those of the private sector.
- However, while 60% of the general hospitals' nursing staff are licensed, DMH units have many more unlicensed than licensed staff. The Department's emphasis on unlicensed nursing staff, apparent in the theoretical ratios, is increased in actual staffing due to the practice of hiring mental health workers in lieu of licensed nurses to fill vacant positions.[26]

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[26] In comparing these data it should be noted that whereas licensed nursing staff reported for the general hospitals were specifically identified as direct care staff, those reported for the DMH-operated inpatient units include staff with administrative responsibilities.

APPENDIX E

Notes to Tables 11 - 41

Tables 11 - 41

APPENDIX E

Notes to Tables 11-41

1. All tables are based on FY'82 data except where noted.

2. FY'82 includes the period from 7/1/81 to 6/1/82.

3. All time periods are reported in years.

4. Currently funded positions are those funded as of 6/1/82, according to personnel records.

5. Currently filled positions are those filled as of 6/1/82, according to personnel records.

6. Currently vacant positions are those vacant as of 6/1/82, according to personnel records.

7. Currently funded, currently filled and currently vacant positions are reported as full-time equivalencies. Other data are reported based on number of full-time and part-time employees.

8. Turnover rates and quick turnover rates do not include layoffs that occurred during FY'82. Layoffs are included as terminations in other calculations. Data on layoffs were obtained through review of Central Office documents.

9. In length of employment and staff-to-patient ratio tables, staff employed "in lieu" are counted in the categories of their actual job, e.g. an MHA hired into an RN position is treated as an MHA. In other tables, staff employed "in lieu" are counted in the positions into which they were hired.

10. "Total geriatric" includes three inpatient units, one at Metropolitan State Hospital, one as Taunton State Hospital and one at Worcester State Hospital, that provide services to geriatric patients from several catchment areas. "Total non-geriatric" includes one other unit at each of these hospitals, and two units at Danvers State Hospital; each of these provides psychiatric inpatient services for a specific mental health catchment area.

11. Number of beds and number of patients, used in calculations of staff-to-patient ratios, were obtained from respondents of interviews, as described in Report I. All other data are from personnel records, as described in Report II.

Table 11

DRAFT

Number of Currently Funded Nursing Positions (RNs, LPNs, MHAs), FY'82[1]

	Licensed Staff			Unlicensed Staff				Total
	Total	RN	LPN	Total	MHA's I	MHA's II	MHA's IV	
vers								
Lynn	17	9	8	14	11	2	1	31
Haverhill/ Newburyport	21	12	9	31	22	9	-	52
topolitan								
Geriatric	16	10	6	62	50[a]	12	-	78
Tri-City	34	12	22	40	33[b]	7	-	74
nton								
Brockton	23	11	12	40	32	8	-	63
New Bedford	59	21	38	43	34	9	-	102
ester								
Regional Geriatric	40	22	18[c]	75	59[d]	16	-	115
North Central	36	19	17	41	34	7	-	77
al	246	116	130	346	275	70	1	592

of 6/1/82

3 of these on loan to Tri-City

1 of these on loan to Met-Geriatric

2 of these on loan to a psychiatric nursing home in the community.

6 of these on loan to a psychiatric nursing home in the community.

Table 12

Number of Vacancies[1]: All Nursing Staff (Prs, LPNs, MHAs), FY'82

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	Licensed Staff			Unlicensed Staff				Total
	Total	RN	LPN	Total	MHA's I	MHA's II	MHA's IV	
vers								
Lynn	17	7	10	15	13	1	1	32
Haverhill/ Newburyport	10.6	6.6	4	11	10	1	0	21.6
ropolitan								
Geriatric	15	10	5	12	12	0	0	27
Tri-City	20.6	11.6	9	21	19	2	0	41.6
ıton								
Brockton	9	6	3	11	11	0	0	20
New Bedford	16.5	5.5	11	11	7	4	0	27.5
ester								
Regional Geriatric	10	8	2	23	23	0	0	33
North Central	10	5	5	13.5	12.5	1	0	23.5
l Geriatric	41.5	23.5	18	46	42	4	0	87.5
l Non-geriatric	67.2	36.2	31	71.5	65.5	5	1	138.7
l	108.7	59.7	49	117.5	107.5	9	1	226.2

ber of times between July 1, 1981 and June 1, 1982 that positions were left full partly vacant.

Table 13

Number of Currently Filled Nursing Positions (RNs, LPNs, MHAs), FY'82[1]

DRAFT

	Licensed Nurses			Unlicensed Staff			Total
	Total	RN	LPN	Total	MHA's I	MHA's II	
vers							
Lynn	9	6	3	13	11[a]	2	22
Haverhill/ Newburyport	19	11	8	29	20	9	48
opolitan							
Geriatric	8	4	4	58	46	12	66
Tri-City	32.4	10.4	22	39	32	7	71.4
ton							
Brockton	20	9	11	40	32	8	60
New Bedford	47	19	28	33	28	5	80
ester							
Regional Geriatric	33	16	17	70	54	16	103
North Central	31	17[a]	14	36.5	30.5[b]	6	67.5
l	199.4	92.4	107	318.5	253.5	65	517.9

f 6/1/82

a one employee on educational leave since 9/27/81
b one employee on leave due to industrial accident since 3/5/81

Table 14

DRAFT

Percentage of All Nursing Staff Positions Filled "In Lieu"[1] FY'82

	N	Licensed Nurses Total %	%RN	%LPN
ers				
Lynn	2[a]	22.2	0	7.1
Haverhill/ Newburyport	2[b]	10.5	0	25
politan				
Geriatric	0	0	0	0
Tri-City	19[c]	58.6	28.8	72.7
ton				
Brockton	2[d]	10	11.1	9.1
New Bedford	2[e]	4.2	0	71
ster				
Regional Geriatric	1[f]	3	0	5.9
North Central	9[g]	29	5.9	57
Geriatric	3[h]	3.4	0	6.1
Non-geriatric	34[i]	30.5	9.4	50
	37[j]	18.6	5.4	29.9

culated as: $\left(\frac{\text{number of positions filled "in lieu"}}{\text{number currently filled positions}}\right)$ 100

a. includes 2 MHAs
b. includes 2 MHAs
c. includes 3 Sr. LPNs and 16 MHAs
d. includes 1 Sr. LPN and 1 MHA
e. includes 2 MHAs
f. includes 1 MHA II
g. includes 1 social worker and 8 MHAs
h. includes e and f
i. includes a,b,c,d,g
j. see a-i, above

Table 15

DRAFT

Number of New Hires[1]: All Nursing Staff (RNs, LPNs, MHAs) FY'82[2]

	Licensed Staff			Unlicensed Staff			Total
	Total	RN	LPN	Total	MHA's I	MHA's II	
ivers							
Lynn	11	4	7	18	17	1	29
Haverhill/ Newburyport	8	5	3	10	9	1	18
ropolitan							
Geriatric	7	4	3	7	7	0	14
Tri-City	27	16	11	23	21	2	50
nton							
Brockton	6	4	2	18	18	0	24
New Bedford	7	4	3	1	1	0	8
cester							
Regional Geriatric	5	4	1	24	23	1	29
North Central	9	4	5	12	11	1	21
al Geriatric	19	12	7	32	31	1	51
al Non-geriatric	61	33	28	81	76	5	142
al	80	45	35	113	107	6	193

ludes part-time employees

of 6/1/82

Table 16

DRAFT

Number Terminated[1], All Nursing Staff (RNs, LPNs, MHAs) FY'82[2]

	Licensed Nurses			Unlicensed Staff				Total
	Total	RN	LPN	Total	MHAs I	MHAs II	MHAs IV	
vers								
Lynn	17	7	10	41	36	4	1	58
Haverhill/ Newburyport	7	5	2	11	9	2	0	18
ropolitan								
Geriatric	8	5	3	10	10	0	0	18
Tri-City	17	10	7	19	17	2	0	36
nton								
Brockton	3	1	2	16	16	0	0	19
New Bedford	13	7	6	7	7	0	0	20
ester								
Regional Geriatric	12	10	2	15	14	1	0	27
North Central	12	4	8	17	16	1	0	29
l Geriatric	33	22	11	32	31	1	0	65
l Non-geriatric	56	27	29	104	94	9	1	160
l	89	49	40	136	125	10	1	225

ludes part-time employees

of 6/1/82

Table 17

TURNOVER RATE[1]: ALL NURSING STAFF (FNs, LPNs, MHAs)[2]; FY'82

DRAFT

	RATE	BASE
vers		
Lynn	250	55/22
Haverhill/ Newburyport	37.5	18/48
ropolitan		
Geriatric	27.3	18/66
Tri-City	50.4	36/71.4
nton		
Brockton	26.7	16/60
New Bedford	18.8	15/80
cester		
Regional Geriatric	26.2	27/103
North Central	43.0	29/67.5
al Geriatric	24.0	60/249
al Non-geriatric	57.3	154/268.9
al	41.3	214/517.9

alculated as: $\left(\frac{\text{number terminations up to 6/1/82}}{\text{number currently filled positions}}\right)$ 100

ayoffs, not included: Lynn - 3 nursing staff
Brockton - 3 nursing staff
New Bedford - 5 nursing staff

Table 18

TURNOVER RATE[1]: ALL LICENSED NURSING STAFF[2] FY'82

DRAFT

	RATE	BASE
vers		
Lynn	177.8	16/9
Haverhill/ Newburyport	36.8	7/19
ropolitan		
Geriatric	100	8/8
Tri-City	52.5	17/32.4
ton		
Brockton	15	3/20
New Bedford	25.5	12/47
ester		
Regional Geriatric	36.4	12/33
North Central	38.7	12/31
l Geriatric	36.4	32/88
l Non-geriatric	49.4	55/111.4
l	43.6	87/199.4

lculated as: $\left(\frac{\text{number terminations up to } 6/1/82}{\text{number currently filled positions}}\right) 100$

yoffs, not included: Lynn - 1 LPN
New Bedford - 1 LPN

Table19

DRAFT

TURNOVER RATE[1]: REGISTERED NURSES (RNs), FY'82

	RATE	BASE
vers		
Lynn	116.7	7/6
Haverhill/ Newburyport	45.5	5/11
ropolitan		
Geriatric	125.0	5/4
Tri-City	96	10/10.4
nton		
Brockton	11.1	1/9
New Bedford	36.8	7/19
ester		
Regional Geriatric	62.5	10/16
North Central	23.5	4/17
l Geriatric	56.4	22/39
l Non-geriatric	50.6	27/53.4
ls	53	49/92.4

lculated as: $\left(\frac{\text{number terminations up to 6/1/82}}{\text{number currently filled positions}}\right)$ 100

Table 20

TURNOVER RATE[1]: LICENSED PRACTICAL NURSES (LPNs),[2] FY'82

DRAFT

	RATE	BASE
ers		
Lynn	300	9/3
Haverhill/ Newburyport	25	2/8
opolitan		
Geriatric	75	3/4
Tri-City	31.8	7/22
ton		
Brockton	18.2	2/11
New Bedford	17.9	5/28
ester		
Regional Geriatric	11.8	2/17
North Central	57.1	8/14
l Geriatric	20.4	10/49
l Non-geriatric	48.3	28/58
l	35.5	38/107

alculated as: $\left(\frac{\text{number terminations up to 6/1/82}}{\text{number currently filled positions}}\right)$ 100

ayoffs, not included: Lynn - 1 LPN
New Bedford - 1 LPN

Table 21

TURNOVER RATE[1]: UNLICENSED NURSING STAFF (MHA's)[2], FY'82

	RATE	BASE
vers		
Lynn	300	39/13
Haverhill/ Newburyport	37.9	11/29
ropolitan		
Geriatric	17.2	10/58
Tri-City	48.7	19/39
nton		
Brockton	32.5	13/40
New Bedford	9.1	3/33
ester		
Regional Geriatric	21.4	15/70
North Central	46.6	17/36.5
l Geriatric	17.4	28/161
l Non-geriatric	62.9	99/157.5
l	39.9	127/318.5

culated as: $\left(\frac{\text{number terminations up to 6/1/82}}{\text{number currently filled positions}}\right) 100$

offs, not included: Lynn - 2 MHA's
Brockton - 3 MHA's
New Bedford - 4 MHA's

Table 22

QUICK TURNOVER RATE[1]: ALL NURSING STAFF (RNs, LPNs, MHAs)[2], FY'82

DRAFT

	Licensed Staff (RNs, LPNs)			Unlicensed Staff (MHAs)			Total		
	Base		%	Base		%	Base		%
vers									
Lynn	6/11	=	54.5	23/18	=	127.8	29/29	=	100
Haverhill/ Newburyport	4/8	=	50	4/10	=	40	8/18	=	44.4
ropolitan									
Geriatric	5/7	=	71.4	2/7	=	28.6	7/14	=	50
Tri-City	12/27	=	44.4	14/23	=	60.9	26/50	=	52
nton									
Brockton	2/6	=	33.3	10/18	=	55.6	12/24	=	50
New Bedford	7/7	=	100	1/1	=	100	8/8	=	100
cester									
Regional Geriatric	4/5	=	80	8/24	=	33.3	12/29	=	41.4
North Central	10/9	=	111.1	9/12	=	75	19/21	=	90.5
al Geriatric	16/19	=	84.2	11/32	=	34.4	27/51	=	52.9
al Non-geriatric	34/61	=	55.7	60/81	=	74.1	94/142	=	66.2
al	50/80	=	62.5	71/113	=	62.8	121/193	=	62.7

alculated as: $\left(\frac{\text{number terminated who worked} \leq 1 \text{ year up to } 6/1/82}{\text{number of new hires up to } 6/1/82}\right) 100$

ayoffs, not included: Lynn - 1 licensed staff, 2 unlicensed staff
Brockton - 3 unlicensed staff
New Bedford - 1 licensed staff, 4 unlicensed staff

Table 23

DRAFT

INTERNAL TURNOVER RATE[1]: ALL NURSING STAFF (RNs, LPNs, MHAs), FY'82

	Licensed Staff			Unlicensed Staff			Total
	Total	RN	LPN	Total	MHA I	MHA II	
vers							
Lynn	66.7	16.7	166.7	127.3	130.8	100	104.5
Haverhill/ Newburyport	10.5	9.1	12.5	0	0	0	4.2
ropolitan[a]							
Geriatric	N/A	N/A	N/A	N/A	N/A	N/A	—
Tri-City	N/A	N/A	N/A	N/A	N/A	N/A	—
rton							
Brockton	0	0	0	2.5	3.1	0	1.7
New Bedford	10.6	21.0	3.6	0	0	0	6.2
ester							
Regional Geriatric	9.1	18.8	0	2.8	3.7	0	4.8
North Central	12.9	5.9	21.4	13.1	21.9	16.7	17.8
1 Geriatric avail.	10.2	20.5	2.04	1.3	1.6	0	4.5
1 Non-geriatric available	10.8	5.6	15.5	16.1	17.2	9.1	14.0
1 available	10.5	11.9	9.3	8.8	9.5	4.6	9.5

lculated as: $\left(\frac{\text{number terminated, FY'82, who moved to another position within DMH system}}{\text{number currently filled positions, 6/1/82}}\right)10$

rminations include part-time employees; currently filled positions are full-time or ll-time equivalents.

[a] Reason for terminations not consistently provided

Table 24

Average Length of Vacancies[1]: All Nursing Staff (RNs, LPNs, MHAs), FY'82

DRAFT

(Reported in Years)

	Licensed Nurses			Unlicensed Nursing Staff			
					MHA's		
	Total	RN	LPN	Total	I	II	IV
ers							
Lynn	.21	.44	.08	.12	.11	.42	0
Haverhill/ Newburyport	.27	.37	.11	.12	.09	.33	0
opolitan							
Geriatric	.32	.29	.36	.21	.21	0	0
Tri-City	.15	.19	.10	.24	.17	.96	0
ton							
Brockton	.33	.37	.25	.08	.08	0	0
New Bedford	.17	.20	.13	.33	.33	0	0
ester							
Regional Geriatric	.32	.17	.92	.12	.13	0	0
North Central	.12	.21	.05	.12	.13	0	0
l Geriatric	.19	.11	.32	.15	.15	0	0
l Non-geriatric	.20	.28	.10	.15	.12	.53	0
l	.19	.23	.13	.15	.13	.44	0

cancies are the number of times between July 1, 1981 and June 1, 1982 that positions e left fully or partly vacant.

Table 25

Average Length of Current Vacancies[1]: All Nursing Staff, FY'82
(Reported in Years)

	Licensed			Unlicensed			Total		
	N	M	(Range)	N	M	(Range)	N	M	(Range)
s									
n	8	.61	(.08- .67)	1	1.3	(————)	9	.69	(.08-1.33)
erhill/ buryport	26	.65	(.25-1.75)	2	.37	(.08- .67)	4.6	.53	(.08-1.75)
olitan									
iatric	8	1.27	(.25-2.42)	6	.48	(<.08-2.58)	14	.93	(<.08-2.58)
-City	1.6	.5	(.33- .67)	1	.08	(————)	2.6	.34	(.08- .67)
n									
ckton	3	.5	(.25- .75)	0	—	(————)	3	.5	(.25- .75)
Bedford	12	1.45	(.08-6.17)	10	2.32	(.58-5.92)	22	1.85	(.08-6.17)
ter									
ional iatric	7	.48	(.16- .83)	5	.21	(.08- .58)	12	.37	(.08- .83)
h Central	5	.45	(<.08- .75)	4.5	.89	(.16-1.58)	9.5	.66	(<.08-1.58)
Geriatric	27	1.15	(.08-6.17)	21	1.29	(<.08-5.92)	48	1.21	(<.08-6.17)
Non-Geriatric	20.2	.55	(<.08-1.75)	8.5	.72	(.08-1.58)	28.7	.6	(<.08-1.75)
	47.2	.89	(<.08-6.17)	29.5	1.13	(<.08-5.92)	76.7	.98	(<.08-6.17)

nt vacancies are fully and partly vacant positions as of 6/1/82.

Table 27

DRAFT

Length of Employment in Position: All Nursing Staff (RNs, LPNs, MHAs)[1]

	N	Median	(Range)	% Employed <1 Year	% Employed <2 Years
rs					
Lynn	66	< 1 yr.	(.08-13)	65.2	80.3
Haverhill/ Newburyport	66	1-2 yrs.	(.08-21)	38.3	53
politan					
Geriatric	84	2-3 yrs.	(.08-20)	23.8	44
Tri-City	107	< 1 yr.	(<.08-17.4)	52.3	81.3
on					
Brockton	79	1-2 yrs.	(.08-23)	36.7	46.8
New Bedford	103	4-5 yrs.	(.08-25.5)	16.7	25.9
ster					
Regional Geriatric	130	3-4 yrs.	(.08-25)	17.7	33.1
North Central	97	1-2 yrs.	(<.08-21.6)	42.3	60.8
Geriatric	317	3-4 yrs.	(.08-25.5)	19.2	34.1
Non-geriatric	415	1-2 yrs	(<.08-23.3)	46.3	65.3
	732	1-2 yrs.	(<.08-25.5)	34.6	51.8

1 des those terminated in FY'82 and those still employed, 6/1/82

Table 28

DRAFT

Length of Employment in Position: Licensed Nursing Staff (RNs, LPNs)[1]

	N	Median	(Range)	% Employed <1 Year	% Employed <2 Years
ers					
Lynn	16	<1 yr.	(.08-2.6)	75	81.3
Haverhill/ Newburyport	24	1-2 yrs.	(.08-21)	45.8	66.7
opolitan					
Geriatric	17	<1 yr.	(.08-2.8)	64.7	76.5
Tri-City	33	<1 yr.	(<.08-6.8)	54.5	87.9
ton					
Brockton	22	3-4 yrs.	(.08-23.3)	22.7	40.9
New Bedford	61	3-4 yrs.	(.08-22.9)	19.7	31.1
ester					
Regional Geriatric	45	3-4 yrs.	(.08-24.1)	15.6	35.6
North Central	34	1-2 yrs.	(.08-15.5)	38.2	58.8
l Geriatric	123	3-4 yrs.	(.08-24.1)	24.4	39.0
l Non-geriatric	129	<1 yr.	(<.08-23.3)	45.7	67.4
l	252	1-2 yrs.	(<.08-24)	35.3	53.6

[1] udes those terminated in FY'82 and those still employed, 6/1/82

Table 29

DRAFT

Length of Employment in Position: FTs[1]

	N	Median	(Range)	% Employed <1 Year	% Employed <2 Years
ers					
Lynn	12	<1 yr.	(.08-2.58)	75	83.3
Haverhill/ Newburyport	17	<1 yr.	(.08-4.58)	58.8	70.6
opolitan					
Geriatric	9	<1 yr.	(.08-2.75)	66.7	77.8
Tri-City	18	<1 yr.	(<.08-6.75)	66.7	94.8
ton					
Brockton	10	1-2 yrs.	(.33-16.58)	30	70
New Bedford	28	2-3 yrs.	(.08-12.75)	25	39.3
ester					
Regional Geriatric	26	3-4 yrs.	(.08-24.12)	23.1	42.3
North Central	20	1-2 yrs.	(.08-6)	25	55
Geriatric	63	2-3 yrs.	(.08-24.12)	30.2	46
Non-geriatric	77	<1 yr.	(<.08-16.58)	50.6	74
	140	1-2 yrs.	(<.08-24.12)	41.4	61.4

udes those terminated in FY'82 and those still employed, 6/1/82

Table 30

Length of Employment in Position: LPNs[1]

DRAFT

	N	Median	(Range)	% Employed <1 Year	% Employed <2 Years
ers					
Lynn	4	1-2 yrs.	(.42-2.25)	25	50
Haverhill/ Newburyport	7	4-5 yrs.	(3-31.75)	0	0
opolitan					
Geriatric	8	4-5 yrs.	(1.42-12.67)	0	12.5
Tri-City	15	3-4 yrs.	(.08-33)	40	46.7
ton					
Brockton	12	8-9 yrs.	(.08-27.7)	16.7	16.7
New Bedford	33	12-13 yrs.	(.08-34)	12.1	12.1
ester					
Regional Geriatric	19	7-8 yrs.	(.25-29.5)	5.3	15.9
North Central	14	4-5 yrs.	(.08-25.17)	42.9	42.9
l Geriatric	60	9-10 yrs.	(.08-34)	8.3	13.3
l Non-geriatric	52	4-5 yrs.	(.08-33)	28.8	32.7
l	112	7-8 yrs.	(.08-34)	18	22.3

udes those terminated in FY'82 and those still employed, 6/1/82

Table 31

Length of Employment in Position: Unlicensed Nursing Staff (CHRAs)[1]

DRAFT

	N	Median	(Range)	% Employed <1 Year	% Employed <2 Years
ers					
Lynn	50	< 1 yr.	(.08-13)	62	80
Haverhill/ Newburyport	42	1-2 yrs.	(.25-14.6)	28.6	45.2
politan					
Geriatric	67	2-3 yrs.	(.08-20)	13.4	35.8
Tri-City	74	< 1 yr.	(.08-17.4)	51.4	78.4
ton					
Brockton	57	1-2 yrs.	(.08-18.7)	42.1	49.1
New Bedford	42	6-7 yrs.	(.25-25.5)	14.3	22.6
ster					
Regional Geriatric	85	5-6 yrs.	(.08-25.33)	18.8	31.8
North Central	63	1-2 yrs.	(<.08-21.6)	44.4	61.9
Geriatric	194	3-4 yrs.	(.08-25.5)	16	19.6
Non-geriatric	286	1-2 yrs.	(<.08-21.6)	46.5	64.3
	480	1-2 yrs.	(<.08-25.5)	34.2	50.8

[1] ides those terminated in FY'82 and those still employed, 6/1/82

Table 32

Comparison of Average Length of Employment[1] of Those Terminated and Those Currently Employed[2]: Licensed Nursing Staff (RNs, LPNs),[3] FY'82

DRAFT

	TERMINATED			EMPLOYED		
	N	M	(Range)	N	M	(Range)
ers						
Lynn	8	.75	(.08-2.58)	8	1.16	(.08-2.3)
Haverhill/ Newburyport	6	.90	(.08-2.58)	18	2.69	(.08-21)
opolitan						
Geriatric	8	.91	(.08-2.25)	9	1.46	(<.08-2.8)
Tri-City	17	.87	(<.08-6.75)	16	1.12	(.33-3.5)
ton						
Brockton	3	1.14	(.33-2.67)	19	8.45	(.08-23)
New Bedford	13	3.31	(.08-13)	48	6.37	(.08-22.9)
ester						
Regional Geriatric	12	5.03	(.08-22.5)	33	5.42	(.08-24)
North Central	12	.58	(.08-1.5)	22	2.88	(.08-15.5)
. Geriatric	33	3.36	(.08-22.5)	90	5.47	(<.08-24)
. Non-geriatric	46	.80	(<.08-6.75)	83	3.62	(.08-21)
.	79	1.87	(<.08-22.5)	173	4.58	(<.08-24)

ncludes part-time employees

of 6/1/82

es not include those employed "in lieu."

Table 33

Comparison of Average Length of Employment[1] of Those Terminated and Those Currently Employed[2] in RN Positions,[3] FY'82

DRAFT

	TERMINATED			EMPLOYED		
	N	$\bar{M}$	(Range)	N	$\bar{M}$	(Range)
ers						
Lynn	2	.625	(.42-.83)	2	1.42	(.58-2.25)
Haverhill/ Newburyport	1	1.42	——	6	5.36	(.16-21)
politan						
Geriatric	3	1.38	(.58-2.17)	5	.63	(.08-2.8)
Tri-City	7	.68	(.08-2.6)	8	1.67	(.42-3.5)
ton						
Brockton	2	1.5	(.33-2.67)	10	13	(.08-23)
New Bedford	6	2.64	(.08-13)	27	8.5	(.08-22.917)
ester						
Regional Geriatric	2	1.71	(.25-3.16)	17	5.4	(1.3-16)
North Central	8	.45	(.08-.58)	6	5.4	(1.8-15.5)
. Geriatric	11	2.13	(.08-13)	49	6.62	(.08-22.9)
. Non-geriatric	20	.702	(.08-2.67)	32	6.59	(.08-21)
:	31	1.209	(.08-13)	81	6.61	(.08-22.9)

ludes part-time employees

of 6/1/82

s not include those employed "in lieu."

Table 34

Comparison of Average Length of Employment[1] of Those Terminated and Those Currently Employed[2] in LPN Positions[3], FY'82

DRAFT

	TERMINATED			EMPLOYED		
	N	$\bar{M}$	(Range)	N	$\bar{M}$	(Range)
ers						
Lynn	6	.79	(.08-2.58)	6	1.07	(.08-2.3)
Haverhill/ Newburyport	5	.80	(.08-2.58)	12	1.35	(.08-4.58)
ropolitan						
Geriatric	5	.63	(.08-2.25)	4	1.19	(.25-2.75)
Tri-City	10	1.0	(.08-6.75)	8	.57	(.33-1.75)
nton						
Brockton	1	.42	(———)	9	3.47	(.33-16.58)
New Bedford	7	3.89	(.16-11.4)	21	3.63	(.80-12.75)
ester						
Regional Geriatric	10	5.69	(.08-22.5)	16	5.45	(.08-24)
North Central	4	.85	(.33-1.5)	16	1.93	(.08-6)
al Geriatric	22	3.97	(.08-22.5)	41	4.102	(.08-24)
al Non-geriatric	26	.87	(.08-6.75)	51	1.75	(.08-12.75)
al	48	2.29	(.08-22.5)	92	2.80	(.08-24)

cludes part-time employees

of 6/1/82

es not include unlicensed nursing staff employed "in lieu."

Table 35

Comparison of Average Length of Employment[1] of Those Terminated and Those Currently Employed[2] Unlicensed Nursing Staff[3], FY'82

DRAFT

	TERMINATED			EMPLOYED		
	N	M	(Range)	N	M	(Range)
ers						
Lynn	36	1.27	(.08-13)	14	1.84	(.08-6.3)
Haverhill/ Newburyport	11	3.13	(.16-14.6)	31	3.40	(.16-12.8)
ppolitan						
Geriatric	10	2.51	(.42-8.5)	57	4.06	(.08-20)
Tri-City	19	1.59	(<.08-17.42)	55	2.96	(.08-23)
ton						
Brockton	16	1.25	(.08-6.25)	41	5.34	(.08- 18.67)
New Bedford	7	.80	(.33-2.25)	35	10.08	(.58-25.5)
ester						
Regional Geriatric	15	4.13	(<.08-21.59)	70	6.72	(.08-25)
North Central	17	4.96	(.08-7)	45	2.33	(.08-16)
l Geriatric	32	2.90	(<.08-21.59)	162	6.51	(.08-25.5)
l Non-geriatric	99	2.17	(<.08-17.42)	186	3.32	(.08-23)
l	131	2.35	(<.08-21.59)	348	4.81	(.08-25.5)

cludes part-time employees

of 6/1/82

cludes MHAs employed "in lieu" in licensed nursing staff positions

Table 36

Number Terminated[1] Who Moved Within the System, All Nursing Staff, FY'82[2]

DRAFT

	Total Licensed (RNs, LPNs)	Total Unlicensed (MHAs)	Total
vers			
Lynn	6	17	23
Haverhill/ Newburyport	2	0	2
ropolitan [a]			
Geriatric	N/A	N/A	N/A
Tri-City	N/A	N/A	N/A
nton			
Brockton	0	1	1
New Bedford	5	0	5
rcester			
Regional Geriatric	3	2	5
North Central	4	8	12
tal Geriatric Reported	9	2	11
tal Non-geriatric Reported	12	26	38
tal Reported	20	28	49

Includes part-time employees

A of 6/1/82

[a] Reason for terminations not consistently provided.

Table 37

Number Terminated[1] Who Left the DMH System[2], All Nursing Staff, FY'82[3]

	Total Licensed	Total Unlicensed	Total
nvers			
Lynn	11	24	35
Haverhill/ Newburyport	5	11	16
etropolitan[a]			
Geriatric	N/A	N/A	N/A
Tri-City	N/A	N/A	N/A
aunton			
Brockton	3	15	18
New Bedford	8	7	15
orcester			
Regional Geriatric	9	13	22
North Central	8	13	21
otal Geriatric reported	17	20	37
otal Non-geriatric reported	27	63	90
otal reported	44	83	127

Includes part-time employees

Resigned, retired, laid-off, terminated

As of 6/1/82

[a] Reason for termination not consistently provided.

Table 38

DRAFT

Terminations By Type of Termination[1]: All Nursing Staff (RNs, LPNs, MHAs), FY'82

(Presented as Percentages)

	Total Licensed (RNs, LPNs)			Total Unlicensed (MHAs)			Total		
	N	%Moved	%Left	N	%Moved	%Left	N	%Moved	%Left
vers									
Lynn	17	35	65	41	41	59	58	40	60
Haverhill/ Newburyport	7	29	71	11	0	100	18	11	89
ropolitan[a]									
Geriatric	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tri-City	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
nton									
Brockton	3	0	100	16	6	94	19	5.3	94.7
New Bedford	13	38	62	7	0	100	20	25	75
ester									
Regional Geriatric	12	25	75	15	13	87	27	18	82
North Central	12	33	67	21	24	76	29	28	72
al reported	64	68.8	31.2	111	25	75	175	27	73

o types of termination are considered. "Moved" includes those who moved to another sition within the DMH system. "Left" includes those who resigned, retired, were laid f or terminated.

Reason for termination not consistently provided.

Table 39

Non-Continuously Employed[1]: All Nursing Staff (RNs, LPNs, NHAs)[2]

DRAFT

	# non-continuously employed	% of all employees that are non-continuously employed
ers		
Lynn	17	25.8
Haverhill/ Newburyport	9	13.6
opolitan		
Geriatric	4	4.8
Tri-City	4	3.7
ton		
Brockton	14	17.7
New Bedford	24	23.3
ester		
Regional Geriatric	17	13.1
North Central	3	3.1
l Geriatric	45	14.2
l Non-geriatric	47	11.3
l	92	12.6

e are employees who resign and subsequently return, in many cases repeatedly.

udes FY'82 terminations and those still employed, 6/1/82.

Staff to Patient Ratios for Licensed Nurses (RNs, LPNs), DMH-Operated Hospitals, by Inpatient Unit

	DANVERS		METROPOLITAN		TAUNTON		WORCESTER	
	Lynn	Haverhill Newburyport	Geriatric	Tri-City	Brockton	New Bedford	Regional Geriatric	North Central
Beds	23	40	55	63	60	90	122	81
Patients	19	37	54	61	58	89	95	94
Funded Licensed Nurse Positions	17	21	16	34	23	59	41	36
Filled Licensed Nurse Positions	9	19	8	31.8	20	47	35	31
Theoretical Licensed Nurse/Patient Ratio[1]	.74:1	.53:1	.29:1	.54:1	.38:1	.66:1	.34:1	.44:1
Filled Licensed Nurse/Patient Ratio	.47:1	.51:1	.15:1	.52:1	.34:1	.53:1	.37:1	.33:1
Actual Licensed Nurse/Patient Ratio[2]	.37:1	.46:1	.15:1	.26:1	.33:1	.51:1	.34:1	.22:1

Table 40

[1] Theoretical Licensed Nurse/Patient Ratio: based upon the total number of funded positions as determined through analysis of Personnel Data (see Report II), and the total number of beds as reported in interviews with unit staff (see Report I)

[2] Actual Licensed Nurse/Patient Ratio: adjusted for positions filled in lieu (see Table14, "Percentage of Nursing Staff Positions Filled "In Lieu") on loan (see footnotes to Table11, "Number of Currently Funded Positions"), and I.A. (see Footnotes to Table13, "Number of Currently Filled Positions"). Tables appear in Appendix E.

Staff to Patient Ratios for Unlicensed Nursing Staff (MHAs), DMH Operated Hospitals, by Inpatient Unit

	DANVERS		METROPOLITAN		TAUNTON		WORCESTER	
	Lynn	Haverhill Newburyport	Geriatrics	Tri-City	Brockton	New Bedford	Regional Geriatrics	North Central
	23	40	55	63	60	90	122	81
nts	19	37	54	61	58	89	95	94
l MHA ions	14	31	62	40	40	43	75	41
l MHA ions	13	29	58	39	40	33	70	36.5
etical MHA/ nt Ratio[1]	.61:1	.78:1	1.13:1	.63:1	.67:1	.48:1	.61:1	.51:1
l MHA/ nt Ratio	.69:1	.78:1	1.08:1	.64:1	.69:1	.37:1	.74:1	.39:1
MHA/ t Ratio[2]	.74:1	.84:1	1.04:1	.93:1	.70:1	.39:1	.68:1	.46:1

Table 41

Theoretical MHA/Patient Ratio: based upon the total number of funded positions as determined through analysis of Personnel Data (See Report II), and the total number of beds as reported in interviews with unit staff (See Report I).

Actual MHA/Patient Ratio: adjusted for positions on loan (see footnotes to Table 11, "Number of Currently Funded Positions") and on educational leave and I.A. (See footnotes to Table 13, "Number of Currently Filled Positions") MHAs filling licensed positions in lieu also are included (see Table 14, "Percentage of Positions In Lieu") Tables appear in Appendix E.

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH:

OFFICE OF STAFF TRAINING, MANPOWER PLANNING AND DEVELOPMENT

STATE HOSPITAL WORKFORCE MANAGEMENT PROJECT

STUDY NUMBER 1

Report III: Northeast Region Public Sector Psychiatric Hospitals: Recruitment and Employment

December, 1982

Elizabeth N. Rosenthal
Project Director

At DMH, it was recognized that data gathered about Department-operated psychiatric hospitals would be more valuable if analyzed in the context of a broader public sector perspective.[1] It was considered useful to know how workforce recruitment-related efforts and outcomes at these hospitals compared with efforts and outcomes at similar hospitals in other states. In particular, it was considered important to determine whether workforce management problems identified at the DMH-operated hospitals were unique to Massachusetts and, if not, whether other states already had developed strategies to address such problems that could be transfered to Massachusetts.[2]

METHODOLOGY

Site Selection

Twelve states were selected for study. Resource and time constraints permitted only limited investigation into state-related variables that might effect nursing staff recruitment at the different hospital sites. A literature review revealed research on nurse recruitment in the private sector that found interstate, regional and economic differences. For the purposes of this study it was decided to select states that, along with Massachusetts, comprise the

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[1] For a description of the methodologies and findings of research efforts at the DMH-operated hospitals see Report I: "DMH Psychiatric Hospitals: Recruitment" and Report II: "DMH Psychiatric Hospitals: Employment Patterns."

[2] Research on recruitment in the private sector was similarly motivated; see Report IV: "Private Sector Hospitals: Recruitment."

[3] The national Association of Nurse Recruitment (NANR) conducts an annual mail survey of its members. Data from the 1981 NANR survey are reviewed in Report IV, "Private Sector Hospitals: Recruitment."

northeast region. These states included Connecticut, Delaware, Maine, Maryland, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Virginia, Vermont and West Virginia.[4]

Data Collection

The structured interview instrument described in Report I was adapted for use in telephone interviews.[5] The original instrument, which focused on aspects of nursing staff recruitment, was shortened, and new retention-related questions were added. It was expected that responses to the new instrument would prove useful in the analysis of data obtained through research efforts described in Reports I and II of this series. Initial telephone contacts were made with the selected states, using a list of state mental health manpower contacts provided by the Center for State Mental Health Manpower Development, a branch of the National Institute of Mental Health (NIMH).[6] The interviewer who made these contacts explained the intent of the telephone survey and was referred to respondents who were directors of human resources, manpower coordinators, employment and recruitment supervisors in personnel offices and an assistant chief of nursing services.

The telephone interviews lasted from one half hour to one hour

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[4] The District of Columbia, also included by NANR, was dropped from this survey because their public sector psychiatric hospital, operated by the federal government, was considered an atypical case.

[5] For a description of the original instrument, see the "Methodology" section of Report I.

[6] In addition to providing support to individual state mental health agencies for the development of statewide mental health manpower planning and development capabilities, the Center indicated and continues to support an interstate network of public-sector mental health manpower development offices.

and were conducted during the second week in June, 1982. To ensure consistency in data collection, one interviewer conducted all of the telephone interviews. All respondents were guaranteed anonymity.

FINDINGS

The following is a summary of findings on public sector psychiatric hospital recruitment and employment of nursing staff. The findings are based on the previously described telephone interviews with key respondents in twelve northeastern states. In addition to the responses summarized here, those interviewed offered recommendations for improving nursing staff recruitment and employment; these appear in Appendix F.

Recruitment Methods

Respondents were asked to identify the recruitment methods that they use to attract new staff to the hospital. Whereas in Massachusetts the only recruitment method cited by all respondents was the use of personal contacts, in this survey all respondents reported using both personal contacts and advertising.[7]

- All respondents reported using personal contacts as a standard recruitment method. Many included the use of formal contacts (e.g., nursing schools, attending conferences) as well as informal contacts.

[7] For a more detailed discussion of recruitment methods in Massachusetts, see the "Findings" section of Report I.

- All respondents reported that their hospitals advertise for direct care staff, usually in local newspapers; several hospitals also advertise in professional journals.

- In nine of the twelve states, respondents said that they visited professional schools in their recruitment efforts, some extensively and some infrequently.

- Half of the respondents reported attending career days or sponsoring open houses.

- Most respondents did not cite the use of public sector employment and training agencies.[8] Three respondents mentioned the state's civil service list as a source of direct care staff, however, and one of these respondents reported heavy reliance on civil service registers for applicants.

Recruitment Constraints

As in Massachusetts, constraints on recruiting nursing staff

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[8] Examples of public sector employment and training agencies in Massachusetts are the Department of Employment Security (DES) and the Department of Personnel Administration (DPA).

were reported by these respondents to include the poor image of the state system, the nationwide shortage of registered nurses, local private sector competition, and geographic isolation.

- Six of the twelve respondents indicated that the public sector's inability to compete with the private sector regarding salaries and benefits for registered nurses was an employment constraint at state-operated facilities.

- Certain lacks in benefits were reported to be recruitment constraints. These included the lack of continuing education and professional development opportunities, the lack of shift differentials, the lack of flex-time, and the lack of permanent shifts.[9]

- All respondents viewed the image of the state system as a deterrent to recruitment; some added that poor image did not accurately reflect actual working conditions.

- Two thirds of the respondents cited a shortage of nursing applicants, referring to the nationwide shortage of registered nurses, and in particular of psychiatric nurses trained for upper level staff

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[9] A shift differential is the fixed increase to the regular salary paid to an eligible employee who works a less desirable shift. A permanent shift is the fixed work schedule assigned to an employee who then works the same hours each work day.

positions.[10]

- Local competition commonly was identified as a factor contributing to recruitment difficulties. (For one respondent it was identified as the main recruitment constraint.)

- The geographic isolation of some facilities not only from population centers but also from professional schools was mentioned by several respondents as a recruitment constraint.

Recruitment Incentives

As in Massachusetts, respondents cited some benefits (retirement and medical benefits) as recruitment incentives. Some respondents also considered salaries, shifts and working conditions to be recruitment incentives in their states.

- Four of the twelve respondents reported that salaries and benefits in their hospitals were competitive.

- One respondent cited fixed shifts at the state hospitals as a recruitment incentive.

- Some respondents reported that working with the public sector's patient populations has particular rewards.

[10] Only one respondent reported a nursing shortage of such magnitude that, as in Massachusetts, a hospital actually had been denied its Medicaid reimbursement. (See Preface, Appendix A.)

Recruitment Results

Interview data revealed that, as in Massachusetts, registered nurses are more difficult to recruit than are other nursing staff. Responses are summarized in Table 42, Appendix H.

- Respondents uniformly identified registered nurses (RNs) as the most difficult direct care staff to recruit.

- The recruitment of licensed practical nurses (LPNs) usually was not seen as a serious problem.[11]

- Respondents reported no problems in the recruitment of unlicensed nursing staff and attributed this primarily to the relatively low level of qualifications required.[12]

Employment Issues

Most respondents indicated that unlicensed nursing staff turned over more quickly than licensed nursing staff.

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[11] While recruitment of LPNs was not seen as a serious problem the role of LPNs in the state hospital was cited as a problem. Their responsibilities often were considered interchangeable with those of unlicensed nursing staff and there were few promotional possibilities, thereby causing concern about the "dead-end" nature of the LPNs' job.

[12] The job title for this class or position varies among states.

In general, staff who remained within the system for several years were likely to remain for a long time.[13]

- Unlicensed mental health workers appeared to have the quickest turnover rate, with a substantial number leaving within the first year of employment. A study in one state revealed that one-third of the unlicensed direct care staff hired in 1980 to work in public sector psychiatric hospitals resigned in the same year, with 25% of those who resigned leaving within the first four months.

- Most respondents reported relatively slow turnover among licensed nursing staff. (These staff tend to stay for more than three years.)

- Half of the respondents reported a bimodel distribution of turnover, with some staff staying only a short time and others a very long time; this pattern was reported to be most evident with RNs.

- Respondents reported that newly hired registered nurses in particular tended to move out of the system within eighteen months to three years. Percentages varied among states:
  - in one state the respondent reported that

[13] For a discussion of turnover and quick turnover as retention measures, see the "Methodology" section in Report II.

fifty percent of newly hired RNs left within two years

- a respondent from another state reported that twenty-five percent of the RNs left within two to three years
- in a third state, the report was that RNs with master's degrees tended to leave within eighteen months to two years
- an exit interview study of RNs in yet another state revealed that twenty-eight months was the average tenure for departing nurses.

- Staff working in state-operated psychiatric hospitals for several years (figures varied from three to seven years) were likely to remain within the system for many years.

- One respondent cited the hospital's benefits as conducive to staff retention and believed that the benefit package became increasingly attractive the longer an employee remained within the system.

- Respondents in two states reported almost no inpatient staff turnover, attributing this phenomenon to a "family feeling" engendered at the hospital: "You come home and work at the hospital where your family

has worked for years."

Recruitment Research Efforts

Recruitment-related research on mental health staff conducted during the last three years has included studies of direct care staff in state operated hospitals, studies of nurse recruitment and retention, and a quality of work life study that was in the proposal stage at the time of these telephone interviews.

- In ten of the twelve states contacted, studies had been conducted concerning direct care staff at state operated psychiatric hospitals. These include turnover and attitude studies and exit interviews.

- Five states had compiled reports or had formed study groups specifically devoted to the problems of nurse recruitment and retention. Recommendations that resulted from these studies appear in Appendix G.

APPENDIX F: RESPONDENTS RECOMMENDATIONS FOR IMPROVING NURSING STAFF RECRUITMENT AND EMPLOYMENT

- Increase salaries as a means of aiding recruitment.
- Provide tuition reimbursement.
- Provide more flexible working hours (e.g., split shifts, 12-hour shifts and flex-time).
- Improve working conditions by increasing shift differentials and improving the physical environment of the workplace.
- Provide nurses with bonuses for bringing other nurses into the system.
- Hire more staff specifically to engage in active recruitment.
- Conduct a major advertising campaign to educate the public about the state system and to enhance the system's image.
- Promote staff participation in professional associations.
- Strengthen academic affiliations to support recruitment and research activities.
- Provide continuing education opportunities through in-service programs and workshops at the hospital or nursing schools.
- Increase the number of direct care staff to facilitate the use of release time for orientation and training.
- Provide good supervision.
- Develop meaningful and responsive career ladders.
- Increase nurse involvement in policy-making and management as well as in clinical decision-making.

- Improve working relationships between nurses and other professionals.
- Investigate and promote staffing alternatives.

APPENDIX G: RECOMMENDATIONS FOR NURSE RECRUITMENT AND RETENTION FROM PUBLIC SECTOR RESEARCH CONDUCTED IN NORTHEASTERN STATES

- Use funds available from vacant nursing positions to increase shift differentials.
- Sponsor an annual award luncheon to honor staff nurses who have been nominated by their peers.
- Establish a nurse clinician position for master's level nurses and experienced bachelor's level nurses at a higher administrative and salary level than that of current staff nurses.
- Make administrative as well as clinical career ladders available to nurses.
- Conduct monthly meetings of administrative nurses from state facilities to discuss recruitment and retention of nurses.
- Develop a statewide orientation package designed to be adapted by individual facilities that will improve the orientation process.
- Provide in-service training and staff development through community resources.
- Expand management training programs.

APPENDIX H

Table 1

Responses to Questions Regarding Level of Difficulty in Recruiting Nursing Staff to Psychiatric Hospitals in Twelve Northeastern States

Position	No Difficulty	Some Difficulty	Difficulty	Difficulty Not Known	Not Used
RNs	0	1	11	0	0
LPNs	3	4	1	3	1*
MH Workers	12	0	0	0	0

*Vermont does not use LPNs.

APPENDIX I: TITLE XIX CERTIFICATION PROCEDURE

The DPH certification procedure is as follows:

a) DPH staff survey the facility for compliance with Title XIX standards and write a report of their findings.

b) If the facility is found to meet specified standards, DPH issues a letter of acceptance to the facility and recommends to the Division of Survey and Certification Operation, Department of Health and Human Services (HHS) that the facility be certified.

c) If the facility does not meet standards, DPH forwards a "Statement of Deficiencies" to DMH.

d) The DMH facility's administration then submits a written plan of correction to DPH in response to the cited deficiencies.

e) If the plan of correction is not forwarded to DPH within a designated time-frame or if the plan is determined by DPH to be inadequate, the deficiency letter is then forwarded to the Division of Health Standards and Quality, Health Care Financing Administration, HHS. The facility is then decertified, and becomes ineligible for federal funds.

f) If the plan of correction is accepted by DPH, the facility is assigned deferred status and continues to receive federal funds. DPH may resurvey against the plan of correction at any time during the ensuing year to ensure that the schedule of compliance is being met. If DPH is assured that compliance has been achieved or is imminent, a letter of acceptance is issued that grants either full certification or temporary certification. If the facility is found to be in violation of the plan of correction, DPH can either issue a warning and schedule a resurvey, or recommend decertification.

g) If a facility is decertified the federal government ceases to provide to the Commonwealth funds to support that facility.

For further information on Medicaid regulations, consult Chapter IV of Title 42, Code of Federal Regulations, or contact the Health Care Financing Administration, Department of Health and Human Services, Washington, D.C.

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH:

OFFICE OF STAFF TRAINING, MANPOWER PLANNING AND DEVELOPMENT

STATE HOSPITAL WORKFORCE MANAGEMENT PROJECT

STUDY NUMBER 1

Report IV: Private Sector Hospitals: Recruitment

December, 1982

Elizabeth N. Rosenthal
Project Director

PRIVATE SECTOR HOSPITALS: RECRUITMENT

INTRODUCTION

The report that follows presents data on the recruitment of licensed nurses to private sector hospitals both within Massachusetts and throughout the Northeastern United States. This is the fourth in a series of reports that resulted from a study of recruitment-related aspects of psychiatric hospital workforce management. The study was conducted between April and August 1982 by staff of the Office of Staff Training, Manpower Planning and Development, a unit within the Central Office of the Massachusetts Department of Mental Health (DMH).

BACKGROUND

The study was prompted in part by a demonstrated lack of conformity to staffing requirements of the federal government at several DMH-operated psychiatric hospitals.[1] Specifically, Title XIX surveyors found insufficient numbers of registered nurses at these hospitals.[2] The Department recognized that one probable cause of this insufficiency was the nation-wide shortage of registered nurses, particularly of nurses in the psychiatric specialty.[3] The nursing shortage has been felt throughout the health care industry and inevitably has led to heightened compe-

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[1] See the "Background" section of the Preface to this study.

[2] For a description of the Title XIX review process, see Appendix I which follows this report.

[3] See: Proceedings: Psychiatric Mental Health Nursing Recruitment to the Specialty; U.S. Department of Health and Human Services, Washington, D.C., March 1982.

tition for registered nurses by potential employers.[4] In designing the study, therefore, it was decided to gather date on recruitment practices at the DMH-operated hospitals and comparable data on nurse recruitment practices in the private sector. In particular, it was considered important to determine what recruitment-related problems identified at the DMH-operated hospitals were shared by the private sector and whether the private sector had developed strategies to address such problems that could be transferred to the DMH-operated hospitals.

METHODOLOGY

Data presented in this report resulted from two distinct research efforts. The DMH office of Staff Training, Manpower Planning and Development conducted a study of nurse recruitment at four private sector hospitals located in Massachusetts.[5] The National Association of Nurse Recruiters (NANR) conducted a mail survey of nurse recruiters. It should be noted that throughout this report "nurse recruitment" refers to the recruitment of licensed nurses.

Case Studies of Private Sector Hospitals in Massachusetts

"Private sector" refers to organizations that obtain their funding primarily from non-government sources. Facilities were

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[4] According to the National Association of Nurse Recruiters, the recruitment budgets of hospitals in the northeast region increased by 122% between 1981 and 1982. (See footnote 9.)

[5] Initially five hospitals were included in this study. However, one hospital differs markedly from the others on a number of pertinent variables. In particular, this hospital does virtually no active recruitment. Therefore, these data were not incorporated into the composite findings but were written up as a separate case and that appears as Appendix J.

selected from among Massachusetts hospitals classified by the American Hospital Association Guide as "non-governmental, not for profit" and "investor owned for profit."[6] This source provides a complete list of American Hospital Association (AHA) accredited hospitals in Massachusetts.[7] The facilities from which a composite picture of the recruitment function might be drawn were selected from twenty-eight general hospitals and eight psychiatric hospitals in Massachusetts. The sample size was limited primarily due to time and resource constraints. It was hoped that a case study approach would provide detailed information on recruitment techniques currently used in the private sector that might be transferable to DMH-operated hospitals. It was expected that these findings would be supplemented by data from the larger NPNR sample.

Description of Sites

The choice of hospitals in Massachusetts was influenced by conversations with Boston-area nurse recruiters, nursing school administrators, members of nursing organizations, nursing convention coordinators and executive staff of the Department of Mental Health. Hospitals were selected that provide psychiatric inpatient services either as a single unit within the general hospital or as the hospital's major service. A range of facilities

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[6] American Hospital Association Guide to the Health Care Field, 1981 Edition.

[7] It is worth noting that the DMH-operated hospitals listed are not classified in this guide as providing psychiatric inpatient services.

was chosen, including hospitals with varied reputations, providing either acute or long-term care. One of the hospitals selected is a large, prestigious private psychiatric facility in the Boston area, classified by the AHA guide as providing long-term care. A general hospital was chosen because of its excellent reputation as an innovative nursing environment. A second general hospital is a member of a nurse recruitment collaborative of twenty local hospitals that use similar recruitment techniques. The fourth facility is a small psychiatric hospital with services considered similar to those of the DMH-operated psychiatric hospitals; its reputation is less prominent than those of the first hospitals mentioned.

Data Collection

A structured interview was administered to the individual responsible for nursing recruitment at each hospital. The interview instrument was a revised version of the one described in Report I.[8] Data sought included three kinds of information: first, budget and personnel sources allocated to the recruitment of licensed nurses; second, recruitment methods; and third, the degree of administrative support provided for recruitment activities. Those interviewed included full-time nurse recruiters and a director of personnel responsible for all recruitment. Recruitment for the psychiatric units was distinguished from recruitment for the general units in the two general hospitals.

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[8] For a description of the original instrument, see the "Methodology" section of Report I.

Interviews were conducted during the first two weeks of June 1982 in the recruiters' offices at the selected hospitals sites. Each interview lasted approximately one and a half hours. Those interviewed were offered both personal and institutional anonymity.

NANR Survey of Private Sector Nurse Recruiters In the Northeastern United States

The National Association of Nurse Recruiters (NANR) conducts an annual mail survey of its members.[9] Their northeastern region is comprised of Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Virginia, Vermont, Washington, D.C., and West Virginia.[10] Data for the NANR 1982 survey were collected during the spring of 1982.[11] Therefore, both in terms of geography and time, findings reported by NANR and reviewed here correspond with other findings presented in this study.

CASE STUDY FINDINGS

The findings reported below are based on interviews conducted at four private hospitals in Massachusetts. Two of these are general hospitals with psychiatric units and two are psychiatric hospitals providing only psychiatric services. The findings indicate that while differences exist among hospitals in some

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[9] For further information about this organization or for a copy of the complete 1982 survey, write to NANR, North Woodbury Rd/Box 56/Pitman, N.J., or call (609) 582-1915.

[10] The states included in the public sector telephone survey presented in Report III are from this region.

[11] The survey included questionnaires mailed to 284 members in Northeastern United States. The response rate was 35%.

recruitment areas, basic methods, approaches and activities are consistent across all hospitals.

Nurse Recruiters

All individuals responsible for nursing recruitment are members of the personnel department of their hospitals and were hired with recruitment responsibilities included in their job descriptions. Two were given the title of nurse recruiter and two held high administrative positions in personnel. Educational background ranged from high school diploma to master's degree. Length of employment at the present job ranged from three to eight years. Prior recruitment experience ranged from five to nine years.

Three of the four recruiters received on-the-job training in recruitment. Training consisted of apprenticeships to those who preceded them in these positions, an orientation to the office and the job, and attendance at workshops and seminars. The fourth individual came to the job with extensive personnel experience and upon employment was not considered to be in need of training. All recruiters continue to attend seminars or workshops on recruitment outside the hospital at least annually and feel that this is important in keeping them up-to-date.

Only one of the recruiters is a registered nurse; she continues to work in direct care at a different work setting. The others do not have nursing backgrounds. All respondents expressed the need for nurse recruiters to have a good understanding of the

nursing profession and to work closely with the nursing administration. Two interviewees said that although they spent time learning about nursing in their hospitals, a nurse recruiting nurses would be preferable since it is difficult to understand the specifics of the job without having personal experience. In fact, in one hospital a registered nurse supplements the recruitment activities of the nurse recruiter on a part-time basis, and an effort is underway to extend her hours.

At each of three hospitals, only one person was responsible for nurse recruitment. Two of these devoted 100 percent of their time to nurse recruitment. At the third hospital, the individual interviewed was responsible for recruiting all direct care staff, assisted by other members of the personnel office. She estimated that she spends 80 to 100 percent of her time filling nursing positions. At the fourth hospital, the individual responsible for nurse recruitment devoted 60 to 80 percent of her time to this activity and was assisted by the part-time RN recruiter mentioned above.

General Recruitment Activities

Respondents at all of the hospitals recognized the importance of ongoing nurse recruitment and each participated in a variety of recruitment activities. Many of these, however, were not directed toward filling specific positions. Keeping the hospital name circulating in the nursing community through general ads in nursing publications was an accepted policy. As one recruiter put it, "Direct hires may not be made from these ads,

but being out there for nurses to see who we are serves a purpose." One recruiter felt that nurses who move to Boston apply to her hospital because the name is familar to them from ads or promotional material. A recruiter at one of the psychiatric hospitals said that although only experienced nurses are hired, this hospital finds nurses who, after three years' work experience, apply because of information they received while enrolled in nursing school. General recruitment activities entail advertising in professional journals, attending job fairs and career days[12], and sending promotional material to nursing schools.

The hospitals advertise nationally through the more widely read professional journals -- American Journal of Nursing, Nursing '82 and RN Magazine. Such advertising was rated as a somewhat effective recruitment strategy that addresses the objective of circulating the hospital's name in the nursing community.

Nursing job fairs reach nurses at the regional level. There is an annual Boston Nursing Job Fair, with hospitals throughout New England as well as from other parts of the country participating. The effectiveness of recruiting from the Boston Job Fairs was difficult to judge; recruiters said they were unable to trace the exact source that brings nurses into the hospital. All appli-

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[12] Job fairs are held across the country at different times throughout the year. To participate in a fair, each hospital pays a fee for a booth and expenses of an individual who staffs it. Staff nurses sometimes man the booths at these events. At career days hospital representatives visit colleges and graduate schools and present promotional information as a means of recruiting graduates.

cations taken during the fairs are followed up; anyone whose name was taken or who filed an application is contacted and offered an interview. One hospital participated in a job fair in the midwest, but midwestern nurses manifested little interest in moving to Boston; the hospital will not repeat its membership in that fair.

Career days and nursing school contacts are carried out locally. The nursing departments are primarily responsible for these activities. Nursing school contacts are directed toward recruiting new graduates and include distributing promotional material as well as arranging visits by nursing representatives who discuss the hospital and its job environment.

Participating in nursing job fairs and career days, and maintaining nursing school contacts are time consuming and costly activities. Their effectiveness was not as highly rated as were newspaper advertising and personal contacts, especially in terms of filling specific openings. Yet the hospitals intend to continue these activities to establish and maintain a good public reputation.

Each hospital shows a seasonal increase in recruitment efforts; nevertheless, no consistent peak period has emerged across all hospitals.

Recruitment for Specific Openings

In addition to general marketing campaigns, each hospital advertises for specific job openings. At one psychiatric hospital, when a supervisory position opens an ad is placed in the newspaper. In both general hospitals, when an opening on a speciality unit such as psychiatry occurs that opening is advertised. The two most effective recruitment methods are running classifieds in the Boston Globe and using the personal contacts of the staff. Other local newspapers are used occasionally, but advertising in the Globe has been overwhelmingly effective for this sample. Even medical doctors and psychologists were noted by one recruiter to have a significant impact on recruitment. In hospitals where no referral bonus was offered, staff contacts were still a major source of applicants.

In-house job postings are another effective way to advertise job openings. Job notices are posted near the time clock or on a job board, or circulated to the floors on a job list, or news of the opening travels by word-of-mouth. At the general hospital, a job in a specialty area such as psychiatry is considered a professional advancement for a nurse. Some nurses enter a general floor with the hope of moving into psychiatry when an opening occurs. In other cases, shift changes or the opportunity to be charge nurse is the motivating factor. Recruiters recognize that there is little career advancement in hospital nursing; the hospitals' offerings are limited to these kinds of

career changes. Generally, in-house applicants are encouraged to apply for job openings. In-house advertising is done either before or simultaneously with external advertising; the range was from first advertising in-house for two weeks to advertising internally and externally simultaneously.

At one hospital, timing of internal and external advertising depends upon the position: if a position is known to be easily filled from within, in-house advertising will be conducted first; for difficult-to-fill positions, external advertising is initiated simultaneously with the in-house posting.

Interview and Hiring Procedures

All of the hospitals follow similar procedures for filling staff positions. First the nursing department informs the personnel department of the impending vacancy. Staff give two to four weeks' notice, and usually take earned vacation time during this period. Each recruiter knew the procedure in her hospital and expected to be informed accordingly whenever an opening occurred. The job is then posted in-house, applications on file are reviewed and, in most cases, an ad is placed in the Boston Globe or local newspaper.

In general, recruiters try to interview as many applicants as possible. Respondents had difficulty in determining the average number of applicants per opening, primarily because of the ongoing nature of recruitment. The recruiter and an administrative member of the nursing department interview applicants.

Both interviews take place on the same day and are held at the hospital. The nurse administrator is either the director of nursing, a supervisor or a head nurse. Two hospitals encouraged second interviews for certain jobs; these interviews are held on the floor where the opening exists.

Following the interviews, references are checked and the nurse administrator and the recruiter discuss the applicant and reach a joint decision on hiring. The nursing department seemed to be given a greater say in this decision because of the nurses' ability to judge how "right" the applicant is for the specific job. The job offer is made by the personnel department. Although no written standardized interviewing forms existed in any hospital, both the nursing and personnel departments were aware of and followed each hospital's procedures. Communication and cooperation between the departments was considered effective.

All recruiters felt that an on-site interview and tour was important in the interviewing process. As they explained, "the applicant needs to get an idea of the place," "working with a psychiatric population can be frightening" and if one has some exposure to the environment "a better understanding of the prospective position will result."

Each applicant is given the same information during his or her

interview with the recruiter: benefits, hospital policies, salaries and hospital history. The nurse administrator presents a verbal description of the job's duties and responsibilities during her interview with the applicant. At each hospital the written job description is given to the applicant at a different time, ranging from before the interview to after hiring. No one emphasized the written job description in the initial stage of the interviewing process. During the interviews, recruiters mention positive aspects of working at their hospital; these included a philosophy of allowing the individual to retain his/her own identity, a commitment to accommodating the individual's desire to progress into a leadership or clinical role, a professional atmosphere, a friendly atmosphere and challenging environment. Primary nursing[13], where it is offered, was felt to be a very strong attribute. Although salary and benefits are discussed, the recruiters did not feel that these factors strongly influence an applicant's decision to accept a job offer. Most of the hospitals prefer a one-year work commitment, and this is discussed with applicants during their interviews. Potential drawbacks, including rotation and the difficult nature of psychiatric patients, are also discussed.

Hiring Criteria

Recruiters were asked to rank the importance of certain criteria

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[13] Primary nursing is a method of nursing care where each patient is assigned to a nurse who is then responsible for coordinating that individual's care. This gives the nurses more input into the patient's care plan.

used in hiring an RN, with 1 being least important and 3 most important. The average of their responses appears in Table 43.

Table 43

Hiring Criteria in Private Sector Hospitals*

	Average	Range
Personal impressions**	3.0	3
References	2.5	2-3
Education	2.25	2-3
Experience	2.25	2-3
License	2.0	1-3
Training	1.5	1-3

* Ratings are from 1 to 3, with 1=least important and 3= most important

**In forming personal impressions, recruiters evaluated the individual's presentation, personality and ability to be flexible.

Degree of Difficulty in Hiring

Recruiters were also asked to rate the degree of difficulty in filling nursing positions, with 1 being not difficult at all and 5 being very difficult. Three respondents answered with a 3 and one with a 1.

Recruiters rated the frequency of a rejection when a job was offered for a psychiatric nursing position, with 1 being almost never and 5 being almost always. Two answered with a 1 and two with a 2. The respondents felt that the high acceptance rate was due to hospitals flexibility in hiring. At one hospital at least one shift per week always is offered to a

satisfactory applicant. At another hospital a job will be made even if a vacancy does not exist, since the expenditure can be absorbed by the budget.

Competition with local hospitals was seen as the greatest obstacle in filling nursing vacancies. Criteria for difficulty in filling positions were rated from 1 to 3, with 1 being not important and 3 very important; the average ratings are presented in Table 44.

Table 44

Private Sector Hospitals' Criteria for Difficulty in Filling Positions*

Criteria	Means
Competition from local hospitals	2.75
Shortage of applicants	2.0
Applicants lack experience	1.75
Low salary	1.75
Applicants lack education	1.5
Lack of public transportation	1.5
Working conditions	1.5
Image of patient population	1.5
Image of facility	1.0
Inadequate benefits	1.0

*Ratings are from 1 to 3, with 1 = not important
3 = very important.

The hospital's reputation was felt to be the greatest inducement to nurses who accepted jobs at each hospital. The "friendly

atmosphere," personal atmosphere and small size" as well as the reputation of the hospital as a "pace setter" were cited as attractive features. High demands, the acute clinical setting, low salary and no shift flexibility were identified as disincentives to some nurses.

Orientation Programs

All of the hospitals offer an orientation program to newly hired staff. The specifics varied from hospital to hospital, but orientation generally consists of classroom activities combined with on-the-floor training. The programs range in length from four to eight weeks; flexibility to accommodate an individual's need was emphasized. The directors of inservice or nursing education at the hospitals are responsible for developing and implementing these programs.

Administrative Support for Recruitment

Each hospital has a personnel budget that includes recruitment activities. Budget size varied among hospitals and did not directly correspond to the hospitals' inpatient capacity. All of the respondents consider advertising to be the major recruitment expense. Costs of travel, seminars, promotional material, job fairs and membership in associations are also covered. The recruiters felt two kinds of constraints associated with their budgets: staying within the budget and not having enough freedom in spending it.

The administration at each hospital gives high priority to nursing recruitment and strongly supports recruitment activities. In one hospital where there is an employee referral bonus, the administration regularly reminds the staff that everyone should be recruiting. In another hospital a nursing recruitment committee of staff nurses and the nurse recruiter plan recruitment activities.

Suggestions for Improving Recruitment

The recruiters were asked how recruitment could be improved in their hospitals. "Maintain good public relations, remember that recruitment is ongoing, give recognition to your staff and treat them professionally," were offered by one respondent. Other suggestions were to expand advertising, keep abreast of changes in the field and hire a registered nurse as nurse recruiter.

NANR SURVEY FINDINGS

Nurse Recruiters

According to the 1982 NANR survey, half of the recruiters in the northeastern region work out of a nursing department, 42% work out of a personnel department and most of the rest work out of both. They spend, on average, 63% of their time recruiting nurses. Sixty-four percent of them recruit for other positions as well as for RNs and LPNs; on average, 1.82 other staff personnel work with each recruiter on nurse recruitment. Sixty-two percent of the recruiters have hiring responsibilities; 57% have the responsibility for hiring RNs.

The extent of the recruiters' formal education varies; 46% have a bachelor's degree, 20% have a master's, 14% have a diploma and 8% have an associate degree. More than three quarters of the recruiters are registered nurses (77%).

Nurse recruiters in the northeastern states have an average salary of $22,499, with a range from $13,000 to $34,000. (This figure is lower than the national average reported by NANR.)

Recruitment Methods

The recruitment method most frequently characterized as "most successful" was local advertising. This was followed by career days, individual campus visits and student nurse conventions respectively. Other methods that were mentioned include national nursing journal advertising, career directories, job fairs, non-local newspaper advertising and specialty nurse meetings. ("Word of mouth" referrals and in-house recruiting were listed under "others;" data on the frequency of mentions of these methods were not reported separately by region.)

Recruitment Budgets

The average recruitment budget reported for hospitals in the northeast region during 1982-1983 was $90,532. (Average bed capacity is 430; average budgeted number of full-time equivalent (FTE) RN positions is 319.) According to NANR, this was a regional increase in budget of 122%. Types of expenditures

vary, but usually include travel, advertising and recruitment material, and may include interview arrangements, travel and entertainment of applicants, relocation expenses, seminars and other professional development activities, dinners or luncheons for graduating nursing students, organization dues, convention and exhibit fees, open houses and press conferences.

APPENDIX J: HOSPITAL CASE

The person identifying herself as responsible for nursing recruitment at this small psychiatric facility was the Director of Nursing. She has held this position for three or four years and has worked at the hospital for about thirty-five years. Because there is minimal turnover of nursing staff, she spends little time (less than 10%) on nursing recruitment. Nurses have worked at this hospital for eighteen to forty years.

This hospital does not participate in any ongoing recruitment activities. This year three nurses were hired because nursing coverage was exparded. The hospital placed ads in the local newspapers and successfully attracted applicants. However, the hospital administration, not the Director of Nursing, is responsible for placing ads. The Director of Nursing was not aware of a separate recruitment budget.

Local advertising is the only outside advertising used. Job openings are offered to in-house staff for two to three days before external recruitment begins. In-house job postings, personal contacts and newspapers were rated as effective in recruiting nurses.

Applicants undergo only one interview, which is with the Director of Nursing. The written job description is shown to the applicant before she/he is hired. Past work experience and personal impression during the interview are the most important

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factors in the hiring decision.

Shortage of applicants and applicants' lack of experience were cited as the factors causing the most difficulty in filling vacant nursing positions. Competition from local hospitals was not a factor in nurse recruitment; geographic location was given as the explanation.

Reputation was given as the reason why nurses chose to work at this hospital. The friendly atmosphere and family-like concern for and among staff attracted nurses to the hospital and contributed to their staying for long terms.

Orientation lasts two weeks and is based on peer modeling, with the individual learning the job from another staff member. A written package of hospital rules and regulations is distributed to each new employee. No classroom orientation programs are offered.

Another distinguishing feature of this hospital is that it is the only one interviewed that is currently hiring LPNs to work in psychiatric settings. The other hospitals either had no LPNs working on psychiatric floors or were not replacing or recruiting LPNs for psychiatric positions.

MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH:

OFFICE OF STAFF TRAINING, MANPOWER PLANNING AND DEVELOPMENT

STATE HOSPITAL WORKFORCE MANAGEMENT PROJECT

STUDY NUMBER 1

Report V: Literature Review: Recruitment and Retention

December, 1982

Elizabeth N. Rosenthal
Project Director

LITERATURE REVIEW: RECRUITMENT AND RETENTION

INTRODUCTION

The report that follows presents the results of a review of the published literature on recruitment and retention of personnel in mental health settings. This is the fifth in a series of reports that resulted from a study of recruitment-related aspects of psychiatric hospital workforce management. The study was conducted between April and August 1982 by the staff of the Office of Staff Training, Manpower Planning and Development, a unit within the Central Office of the Massachusetts Department of Mental Health (DMH).

BACKGROUND

This study was conceived as the first effort of an ongoing project on state hospital workforce management. The literature review presented here was intended to be sufficiently broad to provide the basis for both the present study and subsequent project efforts. Hence it addresses both recruitment and retention.

Although the literature review appears as the last report in this series, in fact it was conducted prior to the implementation of the research activities described in the earlier reports. Since then, the Center for State Mental Health Manpower, a branch of the National Institute of Mental Health (NIMH), has

established an inventory of the activities and products of all affiliated state manpower offices. A number of these address aspects of workforce management at their state hospitals, and some, the efforts of the manpower offices in the northeastern states, are referred to in Report III of this series. The inventory is kept up to date through the collaborative efforts of the individual state mental health manpower offices and the Center for State Mental Health Manpower at NIMH.[1]

REVIEW OF THE LITERATURE

Overview

The literature on recruitment and retention of personnel in mental health settings is scant. There is an occassional article on the theoretical underpinnings of staff recruitment or development in state hospitals, but these articles generally focus on high-level staff positions such as psychiatrists. The published research on registered nurses (RNs) and licensed practical nurses (LPNs) in state mental hospitals is very limited. However, there is a growing body of literature on recruitment and retention of RNs in general hospital settings; much of which can be applied to nursing in mental health settings.

Most of the impetus for the empirical and intuitive[2] work on nurse recruitment and retention comes from the current shortage of working nurses. Private hospitals facing severe staffing

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[1] A copy of the inventory can be obtained by writing to the Center for State Mental Health Manpower Development/NIMH/ Parklawn Building/5600 Fishers Lane/Rockville, MD 20857.

[2] Intuitive is used in the sense that a majority of the work is nonempirical and written by nurse recruiters or staff RNs.

difficulties have concentrated unprecedented resources in recruiting and staff development procedures. An analogous situation exists in public sector mental health facilities. An emergent group of articles studies the migration of psychiatrists from public to private sector work. These articles deal with the reasons for the movement from the public sector and propose procedures to aid in both recruitment and retention of psychiatrists or psychiatric residents.

Definition of Terms

Recruitment refers to the set of procedures used to attract personnel to work settings either from education/training centers, from unemployment or from other work settings. Retention refers to the set of procedures used to maintain manpower in the work place; these procedures include orientation, staff development, motivation, morale and job satisfaction.

As a construct, retention is less well defined than recruitment. However, a wider range of theory can be applied to retention efforts by the conscientious hospital administrator. Whereas recruitment procedures published by other hospitals can be adopted by any given hospital,(given adequate resources) retention procedures must be form-fit to the specific work setting. Therefore,administrators troubled by turnover, low productivity, staff deficiencies and the like need to analyze the forces acting within and upon their staffs. Material published by other administrators and by theoreticians who write generally about work climate,

personnel satisfaction and productivity must be applied to specific administrative concerns.

Recruitment

The factors affecting recruitment cluster into three main categories: 1) print and media advertisements; 2) attributes of the nurse recruiter or recruiting department; and 3) the hospital's image in the nursing and nonnursing community. Recruitment procedures in state hospitals consist primarily of advertisements in local newspapers, placements of nursing or psychiatric students after completion of on-site practice and hiring through the Department of Employment Security professional service center. All of these procedures are used by (medical) hospitals in their recruitment programs.

Hospital recruitment departments have found, however, that success depends on the extensiveness of the recruiting techniques. Few, if any, hospitals utilizing modern recruitment methods use only newspaper advertising or only employment services. Instead, a variety of techniques are used.

Perhaps the definitive statement of recruitment theory is the following: "The point is to expand the range and scope of the recruitment effort. The more comprehensive the effort, the greater its chances for success."[3] The sourcebook from which this statement comes lists the following as key persons in the

[3] From Hospital Nurse Recruitment and Retention: A Sourcebook for Executive Management, American Hospital Association, 19

recruitment effort: hospital administrator, nursing service administrator, hospital medical staff, trustees, personnel department, nurse recruiter, nursing staff, public relations staff, education, inservices and staff development departments, support staff and auxiliaries. In other wards, support for the recruiting effort must come from every level in the hospital. Clearly, some positions are more important for the success of the recruitment program, but there must be both support and consistency between the descriptions of work at the hospital given by the recruiting department and what the work is actually like.

Advertising: The Use of Media

LaViolette (1980) states that, next to career days, advertising is the most successful method of recruitment. Local newspapers and national nursing journals are the nurse recruiters' "bread and butter" advertising outlets. However, since so many hospitals use recruitment ads, any one hospital must identify the types of nurses it is trying to reach and the specific selling points of the hospital in order to attract attention. LaViolette suggests the use of outdoor billboards, radio and television. Many hospitals have begun using television in nurse recruitment (Lee, 1980; Preble, 1980; Spence etal, 1981). In television advertising it was determined that it is important not to hire professional actors to play the part of nurses. Instead, actual nurses at the hospital should read scripts of their own design. The same personal approach is effective in print media advertising.

Recruiters and Recruiting Departments

While not all hospitals have recruiting departments, most have a nurse recruiter. The recruiter may or may not be a member of the personnel department, but must have the following attributes:

- the ability to communicate information about the hospital's nursing program to the nursing community (Cunningham, 1979)
- an understanding of the career objectives of the professional nurse
- the ability to work well with both the nursing administration and personnel
- the respect of all levels of the nursing hierachy
- public relations skills
- sound interviewing skills (O'Keefe, 1980)
- the ability to use experience as a nurse in recruitment efforts
- tact, sensitivity, honesty
- a flair for administrative detail and follow-up
- familiarity with immigration laws and regulations, labor laws, general hiring and employment practices and the regional housing situation (Filcmc, 1980)
- credibility (Preble, 1980)

Hospital Image

A major task of the hospital's recruiting department is to present a good image of the hospital to the community it serves. Of particular importance is the hospital's image to nursing community members. Recruiting strategies for the nursing community include:

- personal contact - use of current RN staff to communicate to other RNs in the community (Spence et al, 1981)
- visits to nursing schools
- conventions and career days
- community seminars (Brown, 1976)

A good public image enhances a hospital's ability to recruit nurses. The cooperative nurse recruitment campaign of the Hospital Council of the Greater Milwaukee Area is one example of a comprehensive recruitment and public relations effort (Neely, 1980). Another hospital changed its name to "Family Hospital" to create a new community image and publicity that focused on the importance of patients and their families. This hospital also instituted a "Create New Life" campaign consisting of conventions, educational community seminars and internships programs (Brown, 1976).

Retention

Recruitment and retention are intimately related. Many of the techniques of sound recruiting can be carried through to the hos-

pital's retention efforts. Once personnel are recruited into the work setting, special attention must be paid to orientation, staff development and overall job climate.

According to the American Hospital Association, the methods used by hospitals in retention efforts are varied but tend to fall into the categories of job satisfaction and job design, internal relationships, communications programs, educational and staff development programs, scheduling patterns, recognition programs and wages and benefits.

There is little published material on retention theory or method as it specifically relates to state mental hospital nursing staff members. There is, however, a good deal of material on retention of psychiatrists in state mental hospitals, an abundance of literature on orientation and staff development for nurses in hospital settings, and some empirical work on correlates of job satisfaction (which is related to turnover) in psychiatric settings. A summary of the literature on each of these topics is reviewed.

Psychiatric Manpower

Pardes (1979) examined the reasons for the decline in overall growth of the psychiatric profession and described some new federal initiatives designed to encourage more American medical school graduates to specialize in psychiatry. These initiatives consist of major redirections of federal mental health manpower, including emphasis on training for public sector work,

cooperative relationships between academic institutions and understaffed public mental health facilities, and altering the payback policy of the National Health Service Corps scholarships.

In an empirical study, Kresper (1981) found the following long-and-short-term strategies to be persuasive in getting psychiatric residents to choose career work in a state mental hospital. In general, the options suggest total system changes rather than simply financial benefits; although if the financial payoff is great enough it is a highly successful retention technique.

Long-term Strategies

- integration of state mental hospital with other health care provision systems
- development of the ability of hospitals to deliver quality care
- use of allied personnel

Short-term Strategies

- use of part-time work policies
- offer of a broad range of professional activities
- application of the attributes of university-based work

In a related study, Talbott (1979) examined the factors that influence psychiatrists to enter public service and those that eventually cause them to leave. The findings have implications for recruitment and retention efforts in state mental hospitals.

the determination of in-hire salaries.

Feldman (1977) analyzed organizational socialization of hospital personnel. He considered the ways employees were attracted to, recruited by, and developed and trained within hospitals. The stages identified by Feldman are based on organization behavior theory and thus may be applied to staff development in mental hospitals as well as medical hospitals.

Hinkley (1978) points out that no staff development program, regardless of how well thought out, planned, implemented, organized, and warranted, will succeed without administrative support. Administrators must participate in programs, either as listeners or contributors, must make financial allocations for internal programs and for attendance at external ones, and must set aside time for planning the presentation and evaluation of any program.

Littlejohn Associates, Inc. (1975) reviews and analyzes the use of incentive systems for personnel in health care institutions and discusses the general guidelines for implementing such programs in specific work settings.

In addition to these studies, a number of orientation and staff development programs actually used in hospitals and psychiatric units have been published (Jones, 1977; Belanger, 1978; Frohman, 1977; Kent et al, 1978).

Job Satisfaction and Turnover

There is a relatively abundant literature on job satisfaction and turnover for mental health workers. Most articles do not directly address issues of retention. However, by analyzing the factors described in these studies, an administrator may be able to identify forces related to employee retention.

Birch and Davis Associates, Inc. (1980) developed a series of monographs on turnover for the State Alcoholism Authority. The following factors, identified as possibly influencing turnover, can be applied to mental health work settings:

- task distribution by position
- case loads
- appropriateness of staff skills/knowledge for tasks assigned
- heterogeneity vs. homogeneity of staff
- salary levels and fringe benefits
- attractiveness of the facility's environment
- supervisory experience and skills of designated supervisors
- career advancement opportunities
- personnel management policies and practices

A large set of studies demonstrates that there is overlap in performance among employees of various skill levels (Weisman, 1981; Baldonando, 1980; Goldstein et al, 1978; Harari et al, 1979; Frontz, 1978; Strumasser, 1978; Pfeiffer, 1979 and Appelbaum, 1978). It

is common practice to assign the most difficult tasks to lesser skilled employees. Higher level personnel thus spend most of their time performing the least difficult tasks. Psychiatrists, for instance, perform initial diagnosis and administrative work while other personnel carry out the mental health treatment. Similarly, nurses shift the responsibility for the less desirable tasks to aids or other lower level personnel. This distribution of function indicates that the informal organization of work does not necessarily coincide with the formal structure of the organization of work. The ambiguity and overlap of roles has been shown to lead to frustration and high turnover in mental health personnel, especially those in low positions in the organizational hierarchy.

Participation in organizational decision-making has been shown to be an effective strategy for personnel retention. Seybolt (Seybolt et al, 1980) demonstrated that participating in an attitude survey was a successful tool for reversing turnover in a hospital. In a similar vein, Appelbaum (1978) suggested that a joint nurse physician practice committee which encourages nurses to become involved in clinical decision making will improve working conditions.

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